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Guest Editorial

National Rural Health Mission

"Health is fundamental to national progress in any sphere. In terms of resources for economic development, nothing can be considered of higher importance than the health of the people. For the efficiency of industry and agriculture, the health of the worker is an essential consideration. However the loss caused by morbidity is enormous. To this must be added the expenditure to the individual and the State in the provision of medical care. The causes of this low state of health are many including lack of a hygienic environment conducive to healthful living, low resistance to infections primarily due to poor nutrition, lack of safe water supply and of proper removal of human wastes, and most important, the lack of appropriate health care. These are serious impediments to progress." (This is a quote from the chapter on Health in the First five-year plan document which remains true to this day.)

Recognising the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission (NRHM) to carry our necessary architectural correction in the basic health care delivery system.

A close look at the state of Public health in India reveals that Public health expenditure has declined from 1.3% of Gross Domestic Product (GDP) in 1990 to 0.9% of GDP in 1999. The Union budgetary allocation for health is only 1.3% and the Union Government's contribution to public health expenditure is only 15%. Vertical Health & Family Welfare programs have limited synergy at operational levels. There is lack of community ownership of public health programs which impacts on levels of efficiency, accountability and effectiveness. There is also lack of integration of sanitation, hygiene, nutrition and drinking water issues. There are striking regional inequalities. Population stabilization is still a challenge especially in states with weak demographic indicators. Curative services favor the non-poor: for every Re 1 spent on the poorer 20% of the population, Rs.3 is spent on the richest quintile. Hospitalisation leads to Indians spending an average 58% of their total annual expenditure and over 40% of them, borrow heavily or sell their assets to cover expenses. As a result, over 25% of hospitalised Indians fall below poverty line (BPL). Only 10% of Indians have some form of health insurance, mostly inadequate. This incisive analysis points to the defects in the existing health care delivery system.

The National Rural Health Mission seeks to provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralization.

The Plan of Action includes relating health outcomes to determinants of good health like nutrition, sanitation, hygiene and safe drinking water, increasing public expenditure on health, mainstreaming the Indian systems of medicine, reducing regional imbalance in health infrastructure, pooling resources, integration of organisational structures, optimization of health manpower, decentralisation and district management of health programs, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalising community health centers into functional hospitals meeting Indian Public Health Standards (IPHS) in each Block of the Country.

The National Rural Health Mission subsumes key national programs, namely, the Reproductive and Child Health II project (RCH II), the National Disease Control Programs (NDCP) and the Integrated Disease Surveillance Project (IDSP). The National Rural Health Mission will also enable the mainstreaming of AYUSH, i.e. Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health.

The Mission covers the entire country, with special focus on 18 states where the challenge of strengthening poor public health systems and thereby improve key health indicators is the greatest. These are Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam,

Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura.

NRHM lists a set of core and supplementary strategies to meet its goals.

Core strategies:

- Decentralized village and district level health planning and management
- Appointment of Accredited Social Health Activist (ASHA) to facilitate access to health services ASHA will be a female health activist in the community who will create awareness of health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices and provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals Currently ASHA is envisaged in the Empowered Action Group (EAG) States, Assam and Jammu & Kashmir. ASHA must be primarily a woman resident of the village, preferably, in the age group of 25 to 45 years, 'Married/Widow/Divorced' with formal education up to eighth class. Adequate representation from disadvantaged population groups should be ensured to serve such groups better. After going through a community mobilization process, a panel of suitable persons would be drawn up and placed before Gram Sabha. The necessary formalities regarding the selection would be done by the Village Health & Sanitation Committee. States are free to select ASHA as per their own requirements. The norms are "1 ASHA for 1000 population" but for areas like deserts and hilly terrain, these norms may be relaxed. ASHA would not be entitled to any pay or honorarium, but be eligible for compensation for services provided under various schemes and programs of Government of India and State Governments – for institutional delivery under Janani Suraksha Yojana (JSY), for completion of Directly Observed Treatment Short Course chemotherapy (DOTS) treatment under Revised National Tuberculosis Control Program (RNTCP), promotion of household toilets under Total Sanitation Campaign, etc, under the overall guidance of the District Health Mission (DHM). A drug kit will be provided to each ASHA after adequate training. Contents of the kit will be based on the recommendations of the expert/ technical advisory group set up by the Government of India. ASHA would be accountable to the community through the Gram Panchayat. The Anganwadi Worker (AWW) and the Auxillary Nurse Midwife (ANM) would guide her. She would report to the Village Health & Sanitation Committee of the Gram Panchayat.

Strengthening the public health service delivery infrastructure, particularly at village, primary and secondary levels. The health care system in India has expanded considerably over the last few decades; however, the quality of services is not uniform, due to various reasons like non availability of manpower, problems of access, acceptability, lack of community involvement, etc. Although it is true that there are existing standards as prescribed by the Bureau of Indian Standards (BIS) for 30-bedded hospital, these are at present not achievable as they are very resource-intensive. Hence a less resource intensive standard suited to the requirements of the system has been developed and is being introduced in order to improve the quality of public health level. These are the Indian Public Health Standards, based on the recommendations of a Task Group under the Director General of Health Services. With ASHA is place, there is bound to be a groundswell of demand for health services and the system needs to be geared to face the challenge. The NRHM aims at strengthening hospital care for rural areas. The Community Health Centre (CHC) is a 30-bedded hospital providing specialist care in Medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. These are the First Referral Units (FRU) as far as curative care is concerned and are also the link between primary care and tertiary care. With the availability of specialist care in these centres, it was felt that these would be the right breaking ground. As a first step, requirements for a Minimum Functional Grade of a Community Health Centre are being prescribed. Further up gradation will be proposed after these minimum requirements have been met. Subsequently, standards for Primary Health Centre (PHC) and Sub-centre (SC) shall also be developed. In order to ensure availability and quality of services, the Indian Public Health Standards provides a yardstick with which to measure the services being

provided in the CHCs. and take up remedial action accordingly.

- Mainstreaming of AYUSH
- Improved management capacity to organize health systems and services in public health
- Emphasizing evidence based planning and implementation through improved capacity and infrastructure
- Promoting the non-profit sector to increase social participation and community empowerment, promoting healthy behaviors, and improving intersectoral convergence.

***Supplementary Strategies* include:**

- Regulation of the private sector to improve equity and reduce out-of-pocket expenses
- Foster public-private partnerships to meet national public health goals
- Re-orientation of Medical Education (ROME)
- Introduction of effective risk pooling mechanisms and social insurance to raise the health security of the poor taking full advantage of local health traditions

The Mission Steering Group under the Chairmanship of the Union Minister for Health & Family Welfare will provide policy guidance and operational oversight at the National level. Ministerial / Secretary level representatives of Planning Commission, Rural Development, Panchayati Raj, Human Resource Development and Health and Family Welfare Secretaries of four States and ten public health professionals nominated by the Prime Minister will be members of the Mission Steering Group.

At the State level, the Chief Minister shall lead the State Health Mission. It shall be co-chaired by the Health Minister with the State Health Secretary, as Convenor, and representation from related Departments, NGOs, private professionals etc. The State Health Mission shall prepare the roadmap for architectural correction of the Health System, including merger/integration of vertical structures; delegation and decentralization of administrative and financial powers; empowering the PRIs; preparation of Operational Guidelines for the implementation of the Mission; logistics arrangements; disease surveillance; Information, Education and Communication (IEC); and Management Information System (MIS).

The District Health Mission shall be led by the Chairman, Zila Parishad, and be convened by the District Head of the Health Department. It shall have representation from all relevant Departments, NGOs and private professionals. However, States can choose their State specific models. The district and sub district arrangements for the Total Sanitation Campaign would be similar to those of the NRHM, and the activities of the Sanitation guided by the District Health Mission. The District Health Mission shall control, guide and manage all public health institutions in the district and at sub-district levels. It will be responsible for preparation and implementation of an integrated District Action Plan in respect of funds received from all funding agencies into the District Health Fund.

It shall guide the micro planning for:

- Selection and training of ASHAs
- Organisation of Health Camps at Anganwadi levels
- Services related to immunisation and institutional delivery
- Mainstreaming of AYUSH infrastructure
- Supply of drugs
- Utilization of United Fund at Sub-centre level
- Strengthening outreach services through operationalisation of mobile medical unit
- It shall also ensure intersectoral convergence among related Departments at district and sub-district levels
- Above all, the DHM shall ensure the accountability of the public health system to the Panchayati Raj Institutions and to the community. The Village Health & Sanitation Committee (VHSC), the standing committee of the Gram Panchayat (GP) will provide oversight of all NRHM activities at the village level and be responsible for developing the Village Health Plan with the support of the ANM, AWW, ASHA and Self Help Groups (SHG). Block level Panchayat Samitis will co-ordinate the work of the GP in their jurisdiction and will serve as link to the DHM. The DHM will be led by the Zila Parishad and will control, guide and manage all public health institutions in the district. States will be encouraged to devolve grater powers and funds to Panchayati Raj Institutions.

Key activities for the Year 2005-06

Common activities, which are uniformly applicable across all States/UTs over and above those, proposed under ongoing programs like RCH and National Disease Control programs are:

- Constitution of State and District Health Missions
- Merger of Health and Family Welfare Societies
- Preparation of State Action Plan, which identifies sectoral needs and priorities
- Finalizing performance benchmarks for Memorandum of Understanding (MOU)
- Signing of MOU between State and Government of India (GOI)
- Preparation of District Action Plans
- Upgrading two CHCs in every district to the level of Indian Public Health Standards, including the provision for two rooms in these CHCs for bringing AYUSH practitioners under the same roof
- Formation of Rogi Kalyan Samitis
- Immunisation strengthening through induction of Auto-disabled syringes and arrangement for alternate vaccine delivery at immunisation sites.
- Organising mobile medical services at district level.
- Organising Health Camp at AWW level on a fixed day in a month for assured services for women and child health care.
- Provision of household toilets.
- Strengthening institutional delivery under Janani Suraksha Yojana (JSY) through provision of escort and referral services by ASHA & subsidized hospital services for BPL women.
- Establishing systems to increase accountability of health systems to PRIs.
    - Selection and training of ASHA, including provision of drug kits.
    - Organising Health Melas as a platform to inform and educate the public on NRHM.
    - Provision of generic drugs, both AYUSH and allopathic, at village, SC/PHC/CHC level, for common ailments.
- Improvement in the availability of specialist services in the CHCs by ensuring availability of all the sanctioned specialists. Additional sanction of the post of Anaesthetist and Public Health Manager is also envisaged.
- Strengthening support staff, by recommending a Public Health Nurse and an ANM in all these Centres, in addition to the existing staff.
- Norms for infrastructure, equipment, laboratory, blood storage facilities, and drugs have been formulated.
- Guidelines for management of routine and emergency cases under National Health programs are being provided to all CHCs, to maintain uniformity, and also optimum standardized treatment.

The role of NGOs has been defined. NGOs are to be included in institutional arrangement at National, State and District levels, including Standing Mentoring group for ASHA. They should be included as members of various Task Groups. They are to be considered as Health Resource Organisations for provision of training, Behaviour Change Communication (BCC) and technical support for ASHAs/DHM, service delivery for identified population groups on select themes and for monitoring and social audit.

The hour has arrived for all public health professionals to prove their worth. The Indian Public Health Association promises to contribute with all their expertise and experience towards implementing, evaluating and improving the Mission Strategies and collaborate and co-ordinate with peers to generate and foster an efficient, accountable and effective roadmap to realise the Mission goals. It is a privilege for us to facilitate translation of the principles of National Rural Health Mission into practice so as to realise the dream of "Health for All and All for Health."

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M. Dobe
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Indian Journal of Public Health

Editorial

National Rural Health Mission: From Idea to Action

12th April 2005 was a historic day in India when our Honorable Prime Minister, Dr. Manmohan Singh launched "The National Rural Health Mission". With a budget outlay of Rs.6500 crores for 2005-06 and a commitment of the government to raise public health expenditure from 0.9% to 2-3% of GDP, the goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children, with initial focus on 18 "high focus" states.

Debates sparked off with some branding it as yet another promise based on questionable premises to a long suffering rural population and others welcoming the initiative as a historic opportunity to strengthen public health in rural (and urban) areas.

What needs to be realised is that the Mission is an evolving concept. Further, it could even act as a much-needed revitalizer, a resuscitator to a weak and dysfunctional public health system of rural (and urban) India. The Mission actually provides Public Health specialists unique opportunities to promote health and provide for the health related unmet needs of rural India, riding high on the tide of political commitment. For the first time an attempt has been made to view health in totality and not piece meal. Non-health determinants of health like education, water supply, sanitation and communication have been emphasized in the Mission as also important attributes like decentralisation, intersectoral co-ordination and accountability.

Any successful development program stands on four pillars, i.e. political will, financial resources, administrative infrastructure and scientific leadership. With the political will and financial resources having been committed by the government, what remains is the task to put administrative infrastructure in place and provide for scientific leadership. For long, the medical fraternity has shied away from assuming leadership. As a result policy makers and program managers within the ministry have formulated health programs with inputs provided by NGOs and some academic institutions. In general, Public Health practitioners have been conspicuous by their absence.

To improve health care of rural masses without a dialogue with the Public Health specialists is akin to managing the operation theatres without consultation with the Surgeons!

It is time that the discipline of Public Health be given full recognition along with other specialized subjects and a cadre of Public Health specialists be created at all levels of health system so that right from the stage of conceiving a Public Health idea and through the trimesters of careful planning and program nurturing, a healthy 'fully developed' program can be delivered without going through the trauma of a stillbirth later.

A Mission is a strongly felt commitment- a calling and requires mobilization and co-ordination at all levels to have effective, efficient and sustainable action. Human resource needs of our health system needs to be addressed in a comprehensive manner. This would include a convergence at all levels from paramedical workers, nurses, doctors, to specialists like anaesthesiologists, obstetricians, paediatricians, radiologists and wherein public health specialists provide the scientific leadership. Medical fraternity needs to be mobilized at all levels from the undergraduate students to the faculty and medical colleges need to assume greater responsibility than mere distribution of degrees. Involvement of the paraprofessionals and village level functionaries is of paramount importance. Skills of people in various disciplines like behavioral sciences- sociology, anthropology, psychology, economics, political science and public health engineering need to be woven into the very fabric of health care delivery. Expertise of medical graduate doctors in administrative services, in Parliament and the State legislative bodies need to be utilised to keep NRHM on the agenda. Irrespective of individual ideologies, all political parties need to be

sensitized to the aims and objectives spelt out in the Mission and above all this, the citizens need to be mobilized through proper dissemination and advocacy of NRHM as their continued participation alone will make it sustainable. All this can be accomplished only when people working in the area of Public Health provide leadership in an attempt to translate the idea of the Mission into action.

Success or failure- we as Public Health specialists alone can decide the fate of the Mission by providing leadership from the front. The need of the hour thus is to assume a proactive approach and make utmost use of this opportunity in our endeavour as Public Health people to provide "Health For All".

There can be no simple solutions to the long-standing complex issues related to health and development and in a vibrant democracy such as ours, it is critical to continue with this dialogue and debate. The IPHA through this special issue has made a humble contribution in this direction. The special issue provides a platform for healthy exchange of ideas between different stakeholders namely the government, academic institutions, representatives of voluntary organisations and members of a professional organisation such as IPHA. There is a total consensus and agreement on the primary objective of the Mission that this is an idea whose time has come for action - an action for empowering people to be responsible for their health, thereby truly representing the spirit of Alma Ata declaration, " Health for All and All for Health".

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Madhumita Dobe
Managing Editor

Politics of Rural Health in India

D. Banerji*

Summary

The setting up of the National Rural Health Mission is yet another political move by the present government of India to make yet another promise to the long suffering rural population to improve their health status. As has happened so often in the past, it is based on questionable premises. It adopts a simplistic approach to a highly complex problem. The Union Ministry of Health and Family Welfare and its advisors, either because of ignorance or otherwise, have doggedly refused to learn from the many experiences of the past, both in terms of the efforts to earlier somewhat sincere efforts to develop endogenous mechanisms to offer access to health services as well as from the devastative impact on the painstakingly built rural health services of the imposition of prefabricated, ill-conceived, ill-formulated, techno-centric vertical programmes on the people of India. The also ignore some of the basic postulates of public health practice in a country like India. That did not substantiate the bases of some of their substantive contentions with scientific data obtained from health systems research reveals that they are not serious about their promise to rural population. This is yet another instance of what Romesh Thaper had called 'Baba Log playing government government'.

Keywords: political dimensions, rural health politics, NRHM, AYUSH, people's health, SAP.

Political Dimensions of the National Rural Health Mission

In the formation of the National Rural Health Mission (NRHM)[1] we hear echoes of what Rudolf Virchow had said in that fateful year of 1848 – that health is politics and politics is health, as if people matter[2]. Despite making numerous solemn promises to improve the situation since India gained Independence, the state of the rural health services to this day is extremely unsatisfactory. This is rooted in the politics of heath and health services of the past. However, to garner the rural votes, during the 2004 elections, some political parties expressed 'deep concern' over these shortcomings and made yet one more promise to rectify the conditions. After the elections, they brought together some other parties to form of the United Progressive Alliance (UPA), which was able to form the government at the Centre. Improvement of the rural health services was included as a part of the Common Minimum Programme (CMP) agreed to by the UPA.

The obviously limited political commitment to improving rural health services has confined the NRHM mostly to some superficial issues that have come in the way of development of the rural health services. For instance, while the UPA has regretted that India has the unenviable distinction of being among the lower five countries of the world in terms of the percentage of the GDP allotted to the health services (0.9%) [1], it has not analyzed the politics of the of the process of the steady decline of the percentage over the years. The same considerations have led to their ignoring the fact that while the public sector heath expenditure accounts for some 70-90 per cent of the total health service expenditure in rich European countries, it hovers around 20 per cent in India. The CMP contains promise to increase the expenditure to '2-3% of the GDP' in the five years of the rule by the PHA. The budgetary allocations for the first two years do not appear very promising [3]. Furthermore, because of its very apparently limited purpose, the NRHM has got to be ahistorical in its approach. It has to adopt a simplistic approach to a highly complex problem. It provides little scientific evidence, based on health systems research, to substantiate its recommendations. Even a cursory look at the history of public health in the country will expose many serious flaws in the

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formulation of the NRHM. These considerations will be taken up in some detail after a brief review of the trends in health service developments in the past and the politics which has shaped them.

Early Phases of Growth and Development of Health Services

The politics of health and health services was qualitatively very different and much more powerful during the freedom movement. This was summed up by the National Health (Sokhey) Sub-Committee of the National Planning Committee of the Indian National Congress [4] in 1940. What it has called 'the cornerstone of the scheme of their recommendations' was a Community Health Worker for every 1000 of village population. This worker is trained in practical community and personal hygiene, first aid and simple medical treatment with stress on social aspects and implications of medical and public health work. It also recommended that, 'Practitioners of Ayurveda and Unani systems were to be drawn into the state health systems, after giving them further scientific training when necessary.'

The report of the Bhore Committee[5], submitted in 1946, is to this day regarded as an authoritative document, not only because of its distinguished authorship but because many of its proposals and recommendations continue to be valid even today. It was guided by such lofty principles as 'nobody should be denied access to health services for his inability to pay' and that the focus should be on rural areas, with emphasis on preventive measures and training of what it called 'Social Physicians'.

After Independence, the political soil was not adequate to nurture the seeds of hope that took shape during the freedom struggle. However, during the early years the new rulers were impelled to carry over some of the democratic processes in making decisions concerning health. Taken as a whole, these decisions gave a perspective to public health principles and practices in the country, which was markedly different from the ones preached in the conventional schools of public health in Western countries or elsewhere[6]. Despite considerable difficulties and shortcomings, India could develop an endogenous, alternative body of knowledge that was more suited to the social, cultural, economic and epidemiological conditions prevailing in the country. This led to the emergence of an alternative approach to education, training, practice and research in public health[7]. Mentions of highlights of some of the major decisions are being made to elaborate on the outcome of the pro-poor ambience which lasted during the early years of Independence.

Following the acceptance of the report of the Bhore Committee by rulers of the newly independent country, a start was made in 1952 to set up Primary Health Centres[8] to provide integrated promotive, preventive, curative and rehabilitative services to entire rural populations, as an integral component of a wider Community Development Programme[9] – it sought to be an integrated health services approach as a component of intersectoral action, as was envisaged much later in the Alma Ata Declaration on Primary Health Care[10].

Departments of social and preventive medicine in medical colleges were upgraded to give social orientation to medical education[11,12,13]. Apart from the already existing highly rated institutions like the All India Institute of Hygiene and Public Health[14] and the Malaria Institute of India[15], institutes such as the National Institute of Communicable Diseases[16], National Institute of Health Administration and Education (NIHAE)[17] and the National Tuberculosis Institute (NTI)[18] were established in the 1960s, to provide support to education, training and research to the budding health service system of the country.

During 1961-64, interdisciplinary research work done at NTI received worldwide attention[19]. Perhaps the most remarkable feature of its work was to give primacy to people[20]. Imparting sociological dimensions to epidemiological issues[21], developing people oriented technologies and formulation and use of operational research approach in public health[22,23], can be cited as instances of some other features of the National Tuberculosis Programme (NTP) developed at NTI . NTP was designed to sink or sail with the general health services[20].

The convulsive political changes that took place in the 1970s impelled the Central Government to implement the vision of the Sokhey Committee of having one Community Health Worker for every 1000 people to entrust "People's health on people's

hands"[24]. At least on paper, India had developed a network of health services, which compared favourably with any country in the world with similar socio-economic situation. There was a Community Health Volunteer/Volunteer and a Trained Birth Attendant for every 1000 population, a sub-centre with a male and a female multipurpose health worker for 5000 people, a primary health centre for every 30,000 people and a community health centre for 100,000 persons, with referral and supervisory and supportive echelons which went right up to the national level. As providing health services to the population was considered a responsibility of the government, these services were offered free of charge.

India had thus come quite close to the Alma Ata Declaration on Primary Health Care made by all the countries of the world in 1978[10]. The Declaration included: commitment of governments to consider health as a fundamental right; giving primacy to expressed health needs of people; community self-reliance and community involvement; intersectoral action in health; integration of health services; coverage of the entire population; choice of appropriate technology; effective use of traditional systems of medicine; and use of only essential drugs.

Phases of All Round Decline in Organisation and Management

Not unexpectedly, there were huge gaps between the policy commitments and their implementation. Significantly, as late as in 1982, the government party, which had been ruling the country during the past 35 years, made a major move in the politics of health by coming up very sharply against the heath work done in the country during that period. In the document on its National Health Policy of 1982[25], it had described the health services at that time 'has been largely engendered by the almost wholesale adoption of the health manpower development policies and establishment of curative centres based on western models, which are inappropriate and irrelevant to the real needs of the people and the socio-economic conditions obtaining in the country. The hospital-based disease and cure oriented approach towards the establishment of medical services has provided benefits to the upper crusts of the society, especially those living in the urban areas.' It took another 20 years for the government of India to confess in the 2002 edition of its National Health Policy[26] that the promise made in the 1982 were 'too ambitious' (!!) and that it needed toning down. The NRHM[1] is the latest phase in the making promises to the long suffering deprived sections of the people of the country.

However, the reasonably correct public health commitments made at the initial phases could have been used as a springboard for more effective implementation of the philosophy of Primary Health Care in India. This did not happen. Significant shifts in the power relations between the rich and the poor, both within the country and internationally, came in the way. Even the limited hopes aroused during the early years after Independence were belied.

The seeds of a retreat from the promising start were sown as early as in 1967[27]. A virtual mass hysteria was worked up by the ruling elite and their mentors from foreign countries about the perils of population explosion. A common refrain those days was to exclaim that 'the fruits of development are being eaten away by the exponential growth of population'. It was obviously inconvenient for the proponents of population control to ask the simple question: who had been eating away the so-called fruits of development during the earlier two decades? It was inevitable under the highly polarised power relations that the only way to control population growth among deprived sections was to use force. To get this hatchet work done, the politicians preferred the bureaucrats, who still carried the colonial tradition of imposing the will of their masters on the people. They also lacked adequate technical competence which could embarrass their masters by asking inconvenient questions. Another 'qualification' of bureaucrats is that they are ahistorical - they have short memories, as they frequently hop from one ministry to another. The politicians of all hues, bureaucrats and foreign agencies formed a formidable nexus – a powerful syndicate

The Union ministry of health was crudely 'partitioned' into departments of health and family planning. Family planning was accorded overriding priority by the government[27]. People became the 'targets' of their own government[28,29],. Most of the political parties within or outside the legislatures, the intellectuals and social activists were mute spectators, if not active promoters, of this gross violation of human

rights of the masses of people for three decades[30]. However, as described in detail elsewhere[30], despite almost astronomical allocation of funds to family planning, as compared to other health programmes, the population of the country shot up from 351 millions in 1951 to over a billion in 2001 - 'greater the allocation, the greater is the decennial rise in population growth!' In addition, preoccupation with family planning led to gross neglect of the health services, which were so painstakingly built over the first two decades after Independence.

Then, there were the far-reaching consequences of the responses of the rich countries to the declaration of self-reliance by the poor people of the world at Alma Ata in 1978[31]. Their response was swift and sharp. Knowingly or otherwise, they betrayed profound lack of understanding of the basic philosophy of the Alma Ata Declaration of entrusting "People's health in people's hands", by contending that most of the developing countries were too poor to undertake what they called `comprehensive primary health care'[32]. Instead, in 1979, these descendents of the European Enlightenment virtually fabricated, without producing any scientific evidence, an alternative approach of limiting action to dealing with a few diseases at a time which they claimed to be cost-effective and which can be managed by such countries – and it received a proud place in the *New England Journal of Medicines* a `profound' piece of research[32,33,34,35].

This alternative was called the approach of Selective Primary Health Care (SPHC), which is the very antithesis of the concept of primary health care (PHC)[36,37,38] Under the substantially changed political equations between and within countries, the political leaderships of poor countries were 'persuaded' by rich countries to give up some of the key elements of PHC in their health services in favour of SPHC.

The rich countries mobilised organisations such as the WHO, UNICEF and the World Bank to promote their agenda of SPHC[35,39]. This led to opening up of a virtual barrage of what the international agencies called International Initiatives [39,40,41]. These 'vertical' or 'categorical' programmes were ill-conceived, prefabricated, techno centric programmes, which were imposed on the poor countries of the world. Worse still, despite massive investment running into billions of US dollars in these vertical programmes on a global scale, they have fallen far short of the forecasts made at the time of their launching[42].

Government of India, in its National Health Policy 2002 document[26] makes a forthright 'confession' of the degree to which its health service system suffered for agreeing to the donor driven vertical programmes (including immunization, Tuberculosis and AIDS). It now says: 'Over the last decade or so, the Government has relied upon a 'vertical' implementational (sic) structure for the major disease control programmes. Through this, the system has been able to make a substantial dent in reducing the burden of specific diseases. However, such an organizational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain. Over a long time range, 'vertical' structures may only be affordable for those diseases which offer a reasonable possibility of elimination or eradication in a foreseeable time frame"...

It goes on to state:"It is a widespread perception that over the last decade and a half, the rural health staff has become a vertical structure exclusively for the implementation of the family welfare activities. As a result where there is no separate vertical structure, there is no identifiable service delivery system at all. The Policy will address this distortion in the public health system".

These had been an awe-inspiring demonstration of power of the rich to impose their will on the poor. As late as in 2001, WHO's much publicized Commission on Macroeconomic of Health[43], which, incidentally, included the eminent Indian economist-politician, Manmohan Singh, had strongly advocated adoption of vertical programmes.

In addition to the imposition of the International Initiatives, the International Monitory Fund had imposed conditionalities in return for extending loans to bail out the government of India from the financial morass of the early 1990s. Their Structural Adjustment Programme (SAP) enabled the IMF entry into most vital elements of the governance of the country in the form of influencing budgetary allocations in the country. Dutifully submitting to their dictates, the then Union finance minister Manmohan Singh inflicted a 20 per cent cut in the health budget of 1992-93, without taking into account the inflation[44,45]. The impact of

the SAP on the state health budgets was even more devastating. The decimation of the state funded health service system enormously expanded the space for private initiative. Indeed, the government extended assistance to the private sector in the form of various types of duty exemptions and incentives. The governments were also made to undertake a most unimaginative regime of 'cost recovery' from the pitiably meager allocations made for the government funded health services [44,45,46]. The breakdown of the public health system rapidly expanded the 'market' for the private sector.

The government's moves towards globalization further extentuated this trend of co- modification of the medical services. There has been a mushrooming growth of numerous unregulated profiteering private hospitals, nursing homes, diagnostic centres and other ancillaries of the medical industry. With unabashed political support, unregulated institutions for education of physicians and other health personnel such as dentists, nurses, homeopaths and vaids rapidly expanded in the private sector as they became a lucrative field for making profits at the expense of the suffering of the people..

All these trends point to what Ivan Illich[47] had long ago mentioned as medicalisation of life. Producing dependence – almost addiction – to medicine and generation of iatrogenesis of various kinds, were mentioned by him as maladies of the market driven 'modern' medicine. Systemization of medicine, when healers become a cog of the wider 'system' and its even more awesome manifestation in the form of a still bigger conglomerates –conglamoratisation – have been the more advanced manifestation of this malignant trend in the 'developed' countries[48]. The vast proportion of suffering people of the world, who have lost their endogenously developed coping capacity and who are unable to pay the exorbitant rates charged by the private sector institutions, were left in the lurch – it is a case of Marie Antoinette Syndrome – no free lunch for the poor! Illich's prescription[47] for this dilemma is demystification of medicine and increasing coping capacity of the people to deal with their health problems, as also visualized by Gandhi [49], John Grant[50], the Sokhey Committee[4] and Borremans[51].

Conventional public health organizations have virtually ceased to perform the function of preventive work. Even the work of epidemic control has sharply deteriorated. Information system to identify outbreaks of epidemics and emergency action to control them. as was done even in the colonial days, has long ceased to exist. Even the few of the outbreaks that get reported in news media elicit tepid response from the authorities, including pivotal investigative agencies. People, including those who pretend to take their side, meekly submit to outbreaks of several 'epidemics of epidemics'.

The imposition of the TRIPS regime by the World Trade Organization has led to steep escalation of prices of drugs.

Present State of the Health Services

The foregoing analyses of different phases and facets of the health services of the country make it possible to get an idea of the state of the health services. It will be sufficient here to refer only to a few of major studies.

An Independent Commission on Health in India (ICHI), set up by the Voluntary Health Association of India, which submitted its report to Prime Minister Vajpayee in 1997, had pointed out that the health services 'are in an advanced stage of decay'[52]. Equally expectedly, this evoked little action from the head of the government or from the concerned minister. Documents from the Planning Commission also paint an equally gloomy picture[53,54]. A study of a national sample of community health centres (CHC)[55] by the Programme Evaluation Organization (PEO) of the Planning Commission has revealed that virtually none of them is working at its optimal level. The 1992 and 1998 Rounds of the Family Health Survey [56, 57] revealed that India is among the countries having the highest rates of maternal mortality. The survey conducted by the National Council of Applied Economic Research[58] revealed that, among the poor, expenditure incurred to meet the medical needs is the second most important cause of rural indebtedness.

A newspaper report (the *Pioneer*, New Dehli, April 23, 2005) quotes the Programme Implementation Division of the government of India as saying that with the exception of the (small) States of Nagaland and Harayana, there has been 'zero per cent' growth

in the setting up of Primary Health Centres; the target was 193. The performance in terms of setting up Community Health Centres (CHC) is equally pathetic. As against the countrywide target of 103, merely 11 CHCs were set up during April 2004 and January 2005. The Mission Document[1] too draws a bleak picture – hospitalized Indians, on an average, spend 58% of their total annual income; over 40% of hospitalized Indians borrow heavily or sell their assets to cover expenses; over 25% of hospitalized Indians fall below poverty line because of hospital expenses.

Evidence Base of the of the Approach of the Mission

The approach adopted by the Mission provides a telling evidence of the lack of competence of the political and bureaucratic leadership of the Ministry of Health and Family Welfare (MOHFW) and its advisors to develop thinking to rectify what the ICHI had rightly termed in 1997 as an 'advanced stage of decay of the health services system, particularly the rural health service system of the country'. As mentioned earlier, the Mission has adopted a simplistic approach to a highly complex problem. Instead of considering the health services as a complex, interacting system, they have selected a few catchy slogans such as 'Accredited Social Health Activists' (ASHA), Panchayat Health Committees, Rogi Kalyan Samities, health planning starting at the village and district levels, setting up rural health missions at the district, state and national levels, and so on. It brings to mind what the late Romesh Thaper had mentioned in the context of the Emergency of 1975-77, as 'Baba Log playing government government'.

There are three fundamental infirmities in the Mission Document which seriously erode its credibility for dealing with the daunting task of improving the health situation in rural populations, particularly in the backward regions:

1. The MOHFW seems to be doggedly refusing to learn from the past experiences. The most conspicuous among them was the experience of the large scale employment one Community Health Volunteer (CHV) for every 1000 people, along with setting up of a trained dai in every village, by the Janata Party government, which came to power in the wake of withdrawal of the Emergency. The CHV Scheme, which at one stage had more than 450,000 workers, could not be sustained because of the nature of the power structure in villages. If anything, the class-caste equation has deteriorated much further following the 'mandalisation' of the population. The MOHFW did not learn any lesson from this experience while formulating the centerpiece of the recommendations of the Mission – that of having ASHAs in every village of the country. One of the advisors involved in formulating the NRHM[1] got so much carried away by their 're-invention of the wheel' that he visualized 'These women should emerge as the missionaries dedicated to advancing health in India. Money, medicines and medical facilities will be meaningless without these missionaries'. If he had analyzed the causes of failure of the CHV Scheme, he would have realized that he was unwittingly writing the obituary of the NRHM! One explanation for such a major flaw of thinking in the formulation of the NRHM could be that the bureaucrats of the MOHFW and their political masters had never been very serious about the plight of the deprived sections of the population. Otherwise, how can one explain the 'advanced stage of decay' of the health services six decades after Independence?

2. The MOHFW and its advisors must have suffered from massive blind spots about well established principles of public health practice when they developed their vision of the rural health services. For instance, developing facilities for education and training of Managerial Physicians, who have the epidemiological, managerial, social and political competence to provide leadership in the administration of the health services in the country, ought to have found a key place in the in the Mission Document. It was perhaps necessary for the MOHFW officials to develop the blind spots, because, otherwise it would not have been possible to justify giving dominant positions to unqualified, ministry hopping bureaucrats in the MOHFW, or, for that matter, having physicians with no public health qualification or even experience to occupy key positions in the health administration – sorts of

square pegs in round holes. Other key issues such as the cadre structure at the State and Central levels, epidemiological approach to solving community health problems, social orientation of education and training of different categories of health workers, and line and staff alignments in the drawing up the organizational structure, have been kept out of the range of vision of the Mission. Political leaders have also looked the other way, as these blind spots conveniently fall within the purview of their politics of health and health services

3. The central task for the NRHM was to produce data which would enable the MOHFW to devise the mechanism(s) to make most effective use of the resources — in terms of the funds, technology, organization management, etc — within the constraints of given social, cultural, economic, epidemiological and other such conditions: that is, it was required to find ways of *optimizing* use of resources under given conditions However, NRHM has produced little supportive data for carrying out its elaborate Plan of Action, which encompass a number of key components — technical support mechanisms, including conceptualization of a Programme Management Support Centre and Health Trust of India, role of the Central and State government machinery, Panchyati Raj Institutions, NGOs and paying attention to special problems to the North-Eastern State and Mainstreaming AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy). Thus, it ought to have been a classical problem of systems analysis and operational research[22,24]. The NRHM has failed to substantiate their contentions with appropriate research data derived from health systems research, using such methods: there is no scientific evidence base to justify the proposals made by them will lead to optimization of the use the resources. This is a grave infirmity in the Mission Document. In the absence of supportive scientific evidence, it almost amounts to practice of public health quackery. Furthermore, the system conceived by them excludes such vital elements as health human resource development, cadre structure at the Central and State levels and organizations for conducting health systems research at various levels. The timid mention of 'Action research' goes to show their lack of understanding of the research needs As issues such as nutrition, access to adequate amounts of protected water and proper environmental sanitation has critical bearing on the health status of the rural populations, these also ought to have formed key variables in the analysis of the rural health system. Confining analysis to a truncated portion of the rural health system and that too in the absence of minimal evidence base, cuts at the very root of the approach of the Mission. It will turn out to be a fatal lapse.

The NRHM, should, however, be commended for attempting to make a 'bottom-up' approach to development. It has also gone beyond the somewhat halting steps spelled out in the National Health Policy of 2002 by categorically stating that the 'National Disease Control Programmes for Malaria, T.B.(sic), Kala Azar, Filaria, Blindness and Iodine Deficiency , and Integrated Disease Surveillance Programme shall be integrated under the Mission for improved programme delivery'. The massive Programme under Family Welfare also falls in this category. Not unexpectedly, however, the actual delivery of the services under the National Disease Control Programmes retains their 'essential verticality', as envisaged in the original documents of these vertical programmes. These find mention in the Annexures1-5 of the draft guidelines given in the Indian Public Health Standards (IPHS) for Community Health Centres (CHC), prepared by the NRHM. Had it not been so, echoes of the integrated National Programmes could have been heard all along the line, down to the work specifications of the ASHA.

It is worth noting that the Task Group-III of the NRHM, which was assigned the task of preparing document on IPHS[59], after discussions with the RHM authorities, stated that 'the paper was scaled down to discuss the requirements for the minimal functional grading of the CHCs with scope for further up-gradation'. Essentially, the 'minimal functional grading' was the same as those worked out when the CHC scheme was launched long ago. Furthermore, while the Mission had identified 18 States of the country, 'which have weak public health indicators and/or weak infrastructure', namely, Arunachal Pradesh, Assam, Bihar, Chhatisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya,

Madhya Pradesh, Nagaland, Orrisa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh, this may well turn out to be a Quixotic assignment for the Mission personnel when it is realized (as was demonstrated in PEO Report on CHC and the recent report on Programme Implementation, 2004-5) that very few of the CHCs in the remaining 'non-weak' States of the country come anywhere near fulfilling the 'minimal grades' set by the IPHS of the task Group-III. Under such conditions, visions of such formidable tasks as 'provision of 24-hour service at least in 50% of the PHCs', 'ensuring conformation to IPHS at CHCs', 'public-private partnership', 're-orientating health/ medical education to support rural health issues' and 'pooling of medical care expenses', come very dangerously close to mere wishful thinking.

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Indian Public Health Standards (IPHS) for Community Health Centres

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Summary

The health care system in India has expanded considerably over the last few decades but the quality of the services is not up to the mark due to various reasons. Hence standards are being introduced in order to improve the quality of services. A task group under the chairmanship of Director General of Health Services, Government of India was constituted to recommend the standards to be called as Indian Public Health Standards. IPHS are a set of standards envisaged to improve the quality of health care delivery in the country under the National Rural Health Mission.

Keywords: IPHS, Rural Health Infrastructure, Standards for the Health Centers, Standards for the CHC, Rogi Kalyan Samiti, FRU

Introduction:

Upgrading public health infrastructure in rural areas to measurable standards of quality is a key strategic intervention under the National Rural Health Mission (NRHM)[1]. Standards are a means of describing the level of quality that health care organisation are expected to meet or aspire to. Key aim of the these standards is to underpin the delivery of high quality services which are fair and responsive to client's needs, which should be provided equitably and which deliver improvements in the health and wellbeing of the population. This aim can be achieved if these benefits are delivered to all groups in the society. Standards are the main driver for continuous improvements in quality. The performance of health care delivery organisations can be assessed against these standards.

Rural Health Infrastructure in India[2]

In the public sector in rural India, health care services are provided through a net work of Sub-health Centres (Sub-centres), Primary Health Centres (PHC) and Community Health Centres (CHC).

These centres are established on the following population norms:

A Sub-centre provides interface with the community at the grass root level providing primary health care services. Primary Health Centre is the first contact point between the village community and a qualified Medical Officer in the Public sector. PHCs provide an integrated curative, promotive and preventive health care to the rural population. It has 4-6 beds for in-patient and emergency care and acts as a referral unit for 6 Sub-centres. A Medical Officer and 14 other paramedical and support staff man the PHC.

The Community Health Centre provides specialist services to the rural people and is usually located at the block level. CHC is manned by 4 specialists i.e. a Surgeon, a Physician, a Gynaecologist and a Paediatrician supported by 21 paramedical and other staff. It has 30 indoor beds with one operation theater (OT), labour room, and X-ray and laboratory facilities. It serves as a referral centre for 4 PHCs.

Centre	Population norms	
	Plain area	Hilly/Tribal /difficult area
Sub – Centre (SC)	5000	3000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

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The health care system in India has expanded considerably over the last few decades. There are 1, 42, 655 Sub-centres, 23,109 PHCs and 3,222 CHCs functioning in the country (as of September 2004).

Setting up of Standards for the Health Centres[3]

Such a vast net - work of health centres in rural areas looks impressive. However, the quality of services is not uniform due to various reasons like non-availability of manpower, problem of access, acceptability, lack of community involvement and accountability etc. Hence, standards are being introduced in order to improve the quality of services in these health care centres. Although there are standards as prescribed by the Bureau of Indian standards (BIS) for 30 bedded hospitals, these are at present not achievable as they are very resource intensive. Hence a less resource intensive standard suited to the requirement of the system has been developed.

A Task Group under the Chairmanship of Director General of Health Services, Government of India was constituted to recommend the Standards to be called as Indian Public Health Standards (IPHS). Indian Public Health Standards are a set of standards envisaged to improve the quality of health care delivery in the country under the National Rural Health Mission.

Indian Public Health Standard for CHCs[4]

The NRHM aims at strengthening hospital care for rural areas. It is felt that the existing Bureau of Indian Standard protocol for a 30 bedded hospital is too ambitious to be applied to public health care facilities. Accordingly, the Indian Public Health Standards (IPHS) for CHC has been conceptualized, based on the recommendation of the Task Group. The IPHS is a novel concept to fix benchmarks of infrastructure, including building, manpower, equipments, drugs, quality, through introduction of treatment protocols, and accountability to the public, through the concept of citizen's charter enforced through the hospital management society at the facility level and quality assurance committee at State and District level. As a first step, requirements for a minimum functional grade of a CHC are being prescribed. Further up gradation will be proposed after these minimum requirements have been met.

The objectives of the IPHS for CHC are:

- To provide optimal specialist care to the community
- To achieve and maintain an acceptable standard quality of care
- To make the services more responsive and sensitive to the needs of the community

The salient features of the IPHS for a CHC include a set of assured services such as

- Care of routine and emergency cases in Surgery, Medicine
- 24-hour delivery services including normal and assisted deliveries
- Essential and emergency Obstetric Care including surgical interventions like Caesarian Sections and other medical interventions
- Full range of Family Planning services including Laparoscopy services
- Safe abortion services
- New born care, routine and emergency care of sick children
- Services under all the National Health Programmes (NHP) including Blindness Control, Integrated Disease Surveillance Project (IDSP) and HIV/AIDS
- Other services such as blood storage facility, Essential Laboratory services and referral transport

In addition to the already sanctioned post of 4 specialists (Medicine, Surgery, O&G and Paediatrics), IPHS has recommended 2 more specialist posts: one Anaesthetist and a Public health manager at the CHC level. Under the Blindness Control Programme there is a provision of one Ophthalmologist for 5 CHCs. Support staff is to be strengthened by addition of a Public Health Nurse and an ANM in all these centres

in addition to the existing 21/22 support staff.

Norms for physical infrastructure include location of the centre to improve access to the patients, area/ space for entrance zone, outpatient department, minor OT, injection and dressing rooms, separate wards for males and females, patient area, ancillary rooms, open area separating OPD and Indoor facility, operation theatre, labour room, X ray room, separate public utility rooms for males and females etc. Provision of space for support services such as sterilization and sterile storage, laundry, kitchen, drug and other storerooms and administrative zone has been made. Provision of safe water supply to the staff and the patients, electricity and generator backup facility, telephone, referral transport etc also forms part of the IPHS.

Standard Operating Procedures and Standard Treatment Guidelines for management of routine and emergency cases under National Health Programmes are being provided to all CHCs to maintain uniformity and optimum standardized treatment. A list of equipments needed at CHC incorporating standard surgical sets, normal delivery kit, IUD insertion kit, equipments for anaesthesia, equipment for neonatal resuscitation, materials kit for blood transfusion, equipment for OT and labour room, equipment for radiology and various equipment required under National Health Programmes has been provided in the IPHS document. A list of essential and emergency drugs for a CHC is also provided.

Accurate record maintenance and use of computers has been emphasized.

Capacity development of staff through periodic CME / Training of medical as well as paramedical staff and multi-skilling of paramedical worker would be undertaken. Quality of service is to be maintained at all levels. Rogi Kalyan Samiti (Patient Welfare Committee) comprising of representatives of Panchayati Raj Institutions, civil society and the government with authority to raise resources and to manage the welfare of the CHC would be constituted and be made accountable to the community. Citizen's Charter will be prominently displayed at CHCs. It seeks to provide a framework, which enable citizens to know what services are available, the quality of services they are entitled to, the means through which complaints regarding denial or poor qualities of services are addressed.

Both internal and external monitoring would be done. Monitoring of the laboratory services would be done through internal and external quality assessment scheme. By using a checklist it would be possible to monitor whether the CHC is up to the IPHS.

In the first year of NRHM (2005-06), it is proposed to initiate up gradation of at least 2 CHCs per district to IPHS, for which an amount of Rs. 20 lakhs is being released as first installment. Subsequent release of funds would be based on identification of facility specific needs arrived at through facility survey undertaken by the State Governments. The States have been advised to display Citizen's charter at these facilities, and to develop grievance redressal mechanism to enforce the same. Subsequently, the IPHS for PHCs and Sub-Centres will be developed in order to improve the quality of services at PHC and Sub-Centre level as well.

How will the Mission address the issues of absentee doctors in rural areas?[3]

Availability of doctors and paramedics in rural areas is important to the success of the Mission. The States will examine the possibility and modalities for having district level cadres for doctors and block level cadres for ANMs as resolved in the 7th Conference of the Central Council of Health & Family Welfare Ministers, in August 2003. The District Health Missions will have greater flexibility for engaging the services of private doctors on contractual basis to provide services in public health institutions. Most importantly, the States shall indicate their commitment to devolve the funds and programmes for health and family welfare to Panchayati Raj Institutions under the NRHM, to ensure effective accountability of the Public Health Providers at corresponding levels. The Mission also proposes to involve Professional Medical Associations, viz. Indian Public Health Association (IPHA), Indian Association of Preventive and Social Medicine (IAPSM), Indian Medical Association (IMA), Federation of Obstetricians and Gynaecologists of India (FOGSI) etc. to build peer and professional support for the programme.

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National Rural Health Mission – Hope or disappointment?

Abhay Shukla*

Summary

The recently declared National Rural Health Mission has aroused significant interest, being both welcomed and closely scrutinized, since there is a long overdue and outstanding need to strengthen weak and dysfunctional public health systems in rural India. In this setting, Jan Swasthya Abhiyan (JSA) has been involved in analysing various aspects of the Mission. The concern has been that it should develop in a manner that actually strengthens public health systems in an integrated manner, and that it should empower communities to be involved in the planning and utilization of these systems in a Rights-based framework. In this article, one will draw upon and reflect on a few of the major concerns about NRHM that have emerged during the insightful discussions in JSA.

Key words: Jan Swasthya Abhiyan, ASHA- barrier to success, Public Private Partnership, People's Rural Health Watch.

Some general concerns

Before discussing certain specific components of NRHM, it will be logical to pose two general concerns that emerge from a reading of the Mission documents, and have been observed by some of us who have participated in discussions related to formulation of the Mission. The first concern is that there is no systematic analysis of previous policies, and no major lessons seem to have been learnt from the past. The NRHM documents do not appear to analyse why the Primary Health Care approach was never implemented effectively and the goals of 'Health for All by 2000' have not been met, a quarter of a century after they were declared; why instead of improvements in public health services, we have seen stagnation and even certain deterioration since the 1990s; what are the critical issues related to the recent National Health Policy 2002 which must be reviewed – in short one does not see meaningful analysis which could lead to learning from past policy deficiencies[1,2]. While launching a major nationwide community health worker programme in the form of ASHA, there is no systematic analysis of why the Community Health Volunteer (CHV) scheme of 1978 failed[3]; and while declaring 'public-private partnerships' as an important strategy of the Mission, there seems to be no analysis of the glaring issues related to decades of non-regulation of the private medical sector. Here we may keep in mind that 'those who cannot learn from History are doomed to repeat it'.

A second concern relates to the influence of the globalisation- privatisation framework on the Mission. While this is a National Mission, transnational funded programmes presently seem to have a strong presence compared to augmented national finances for the Mission; and although the aim is to strengthen public health, privatisation-friendly measures appear in various places in the Mission related documents. There appears to be a very strong influence of the RCH programme (with major funding by the World Bank and other international agencies); according to the Annexure 'State, District and Block action plan'[4], the funding for NRHM appears as a consolidated repackaging of various existing national programmes, with the single largest chunk being contributed by the RCH programme. If one examines other annexure circulated with the NRHM Manual, the Annexure on 'State wise allocation for 2005-06'[5] details the funds available for NRHM, which appear to be entirely RCH activity related funds; and the only Annexure dealing with indicators[6] deals entirely with RCH-II performance indicators. While Reproductive and Child Health undeniably should form one important component of such a Mission, the disproportionate influence of a

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single externally funded programme may not be healthy for the integrated strengthening of rural health systems, especially given our history of the dominating and distorting influence of vertical programmes such as the Family Planning programme. Similarly, in the Indian situation of an already debilitated public health system and an overwhelming private medical sector, the need is for urgent and substantial strengthening of the public health system and avoiding any further privatisation oriented measures; however some such measures are mentioned in Mission documents, which are discussed below. In the present year's Union budget, we find no separate financial allocation or additional funds for NRHM; ultimately one of the key criteria to assess the strength of political will supporting the Mission is to see whether a substantial scale of additional domestic funding (not just repackaged external funds) is allocated to the Mission in the coming few years.

ASHA – barriers to success, measures required to overcome them

One of the most 'visible' and politically high-profile interventions of NRHM is the proposed ASHA programme-based on suggestions and examples from the Health NGO sector, and recognising the need for a resident health facilitator at the village level, the idea of having a women health promoter in each village is definitely positive. However, we know that whether it is God or the Devil, both often lurk in the details. In the design of the ASHA programme we see a number of serious concerns which would need to be addressed, for the ASHA to be able to function with even a minimum level of effectiveness[3]:

- **Selection criteria** – at present, an educational level up to eighth class (middle education) is expected for a woman to qualify as ASHA. An analysis of the 1991 census data shows that in the rural areas of the NRHM states in Northern India, over 91% women did not have middle level education – and more recent data shows that this situation has not changed significantly in the subsequent period. In the hierarchical, often caste-ridden villages of North India, if this educational criterion is rigidly imposed, it will impose a bias against women from disadvantaged groups such as poorer women with less formal education, and SC and ST women. Myriad experiences of NGO health worker programmes have shown that insisting on formal education is not necessary provided the training of health workers is properly designed. However, with the present educational barrier, the women with strongest social motivation, women who are representative of deprived groups, are likely to get excluded from the programme.

- **Lack of adequate regular compensation** – In the final programme design, ASHA is supposed to work primarily as a volunteer. She would be compensated on performance of certain specific tasks related to National programmes. However, for her major routine activities such as immunisation, weighing of newborns, facilitating ANC, treating patients, visiting households, giving education to mothers, mobilizing the community etc., as per the financial norms, the maximum compensation from the Village Untied Fund that may be given is mentioned as Rs. 1000 annually, or about Rs. 83 per month. It does not require a great degree of imagination to realise that with such a paltry compensation (equivalent to less than two days of wages in a month) the amount of work that can be expected from the ASHA cannot be very significant. To sustain the motivation and activity of village women working as ASHAs, who would have many other competing work priorities and domestic responsibilities, will be a challenge given the very limited and uncertain compensation they would receive.

- **Limited provisions for First Contact Care** – One of the strongest felt needs expressed by communities is the need for basic curative care being made available within their village. Many NGOs have demonstrated that well trained Health workers can give a wide range of First Contact Care effectively. However, the ability of ASHA to give basic care in simple illnesses is dependent on adequate relevant training, provision of a proper kit and regular replenishment of the range of necessary medicines. The drug list for ASHA as has been presently proposed is extremely limited, and the budgetary norm for drugs is Rs. 50 per month (the same as for CHVs way back in

1978!) which raises doubts about her being made capable to meet people's needs for First contact care. If she is seen as a person who cannot give significant care to persons with health problems, her credibility in the village as a Health facilitator and hence her overall effectiveness may also become limited.

- **Activist or appendage? By her very name** – 'Accredited Social Health Activist' the ASHA is supposed to be an 'Activist' mobilizing people and facilitating their access to health services as a right. However, given the fact that the ANM will be involved in sanctioning her compensation, and she would be reporting to the health system for implementation of various programme related activities, would she be realistically able to function as an 'activist' and lead people to put pressure on non-performing health services? Given the way in which the programme is presently structured, there are strong inhibiting forces to prevent her from really becoming an 'activist' vis-à-vis the health system. Moreover, unless the other levels of the Health system such as PHCs and CHCs are substantially improved, their services upgraded, and the staff made responsive to people claiming Health rights, ASHA would not be able to make much headway in her task of facilitating people's access to health services. In the absence of major programmatic changes, the likely scenario is that ASHA would be placed in a peripheral 'helper' role related to the Health system, but the need for significant compensation to carry out this role might be brushed aside on the pretext that she is an 'activist'!

- **Focus on RCH, possible adverse influence of Family Planning programme** - While the ASHA's role in providing primary medical care at the village level appears weak, a look at the indicators to be used for monitoring her performance shows that out of the eight outcome indicators for ASHA, seven are related to RCH. The strong influences of the RCH programme on NRHM in general have already been noted. In this context, it needs to be seen whether a key component of the RCH programme, the Family Planning component, influences ASHA's functioning in a disproportionate manner, since it has often distorted the priorities of other Primary Health functionaries and has reduced their overall effectiveness.

Most of these concerns stem from the national guidelines for the ASHA programme, which have already been finalized. However, the state level design of the ASHA programme in various states is presently underway; along with addressing the concerns mentioned above, certain principles and guidelines should be followed to substantially re-orient the programme, otherwise it is unlikely that it would achieve its stated objectives:

- The role of ASHA is not to substitute elements of the existing health system, but to complement it and promote its better utilisation. The ASHA should not be viewed as a replacement for any of the functions to be performed by the ANM, Anganwadi worker or other public health functionaries.

- Training of ASHA should be substantial and adequate to equip her for her multiple and reasonably demanding roles, this would require at least about one month of initial training followed by regular (monthly or once in two months) follow up training. Training needs to be a continuous effort, provided over a period of a few years.

- A specially developed cadre of local trainers / facilitators would be required to provide adequate training support and ongoing other types of support to ASHAs. These may be drawn from existing staff or may be newly appointed, but must devote practically full time efforts for supporting the ASHA programme. Lack of such dedicated support would fatally weaken the programme.

- Principal amount of adequate remuneration for ASHA should be assured and de-linked from specific activities, with a small performance linked component if necessary. The remuneration for regular health activities and village level processes could be routed through the Panchayat or Village health committee if required. Monitoring of ASHA should involve social monitoring by the Gram Sabha and Village health committee, and

technical monitoring by the Public health system.

- Adequate budgetary provisions must be made to support all the critical elements of the ASHA programme including training and training compensation, cadre of trainers / facilitators, regular replenishment of the drug kit, remuneration for regular tasks and additional activities done by ASHA, capacity building and support to Village health committees etc.

STRENGTHENING OF PHCs AND CHCs

The strengthening of PHCs and CHCs is an important component of the Mission, which is central to the up-gradation of Health services in rural areas. The intention to adopt and operationalise Indian Public Health Standards (IPHS) for CHCs[7] is a definite step forward. However, while operationalising this process of strengthening, certain key issues may be kept in mind:

- In contrast to a current trend which looks at PHCs as being expendable, it is necessary to ensure that PHCs are substantially upgraded to provide a full range of basic services including primary medical care, institutional deliveries, basic emergency care, and referral transport services. This would require renovation of infrastructure, provisioning of adequate and regular drug supply, functional ambulance facilities, adequate all-round staffing, multi-skilling of paramedicals, and adequate facilities for health professionals with time-bound postings in difficult areas with necessary incentives.

- A 'Generic model for Hospital Management Societies'[8] has been circulated as an annexure to the Mission manual, which would presumably guide societies which would manage CHCs and other hospitals being dealt with by the Mission. This document includes under the Aim and Objectives of the Society – 'Generate resources locally through donations, user fees and other means'. Under the scope of functions of such societies, points include – 'Entering into partnership arrangement with the private sector (including individuals) for the improvement of support services' and 'Developing/leasing out vacant land in the premises of the hospital for commercial purposes'. Such provisions raise an apprehension about the processes that might be followed while managing such Hospital societies, and whether these could lead to semi-privatization of such public hospitals. Specifically, implementation of such societies and related committees (such as Rogi Kalyan Samitis) should not be accompanied by any introduction of user fees or any resort to privatisation; rather the improvement of services should be provisioned through enhanced public funds. The experience of user fees in rural public health facilities, in other developing countries as well as in India, is that such fees can form a significant barrier to utilization of services by the poorest. Exclusion mechanisms (such as the 'BPL' criteria) frequently do not work, and the genuinely poor often end up paying while certain politically influential individuals may avail the benefits.

- While the formulation of 'Indian Public Health Standards' for CHCs is a welcome step, such standards should also be formulated for PHCs, and should mandate Charters of Patient's Rights applicable at various levels. Accountability committees for PHCs and CHCs should involve not only Panchayat leaders, but also representatives of local Community- based organisations, Women's groups, locally active NGOs and Village health committees.

Public-private partnerships

The NRHM documents specify 'Public private partnership' as one of the Mission components. However, given the fundamentally divergent objectives of the Public health system (to provide services to the general population based on public financing) and of the Private medical sector (to run as profitable institutions, providing care to those who can pay), a 'partnership' of such differing institutions needs to be very clearly specified, to prevent its abuse. The variable quality of care, frequent lack of minimum standards, prevalence of irrational practices and often unaffordable price of care in the Private medical sector has been documented by various studies. In this context, the foundation of the relationship between the Public health system and the private medical sector must be effective public regulation of the quality,

rationality and costs of care in the private sector. There is no reason why Indian Public Health Standards cannot be applied to the private sector as well. The long-standing and glaring non-regulation of this proliferating sector and the need for strong, effective measures in this direction are only weakly addressed in the Mission document which does not mention any specific legislative or operational mechanisms and blandly talks of the 'need to refine regulation'[1].

Similarly, any measures under the banner of 'partnership' which may lead to privatization of existing public health services should be strongly questioned and opposed, since the consequence of such privatization has often been introduction of steep user fees, barring the poor and lower middle class from accessing services. The recent episode of attempted privatization of Wadia Hospital in Mumbai, which was blocked by the High Court following widespread public protest, is a case in point. In the same vein, public funding for the private medical sector should be strongly critiqued; the Qureshi Committee which investigated major private hospitals in Delhi (who were beneficiaries of large public subsidies) found major non-compliance with stipulations to provide services to poor patients; this highlights the dangers in unquestioningly relying on profit-making agencies to provide care to the poor. However, the obligations of the Private Sector towards Public Health (in terms of support to National health programmes, surveillance, disease notification etc.) should be emphasized; the overriding role of the Public health system in defining public interest needs to be stressed while enforcing the consequent responsibilities of private medical providers.

Conclusion – need to critically support and influence the Mission; People's Rural Health Watch

In India, given the dismal situation of rural health services in most states, any genuine measure to strengthen the rural public health system is welcome; hence the National Rural Health Mission has aroused many hopes and expectations. The long-overdue renewed attention to public health and most of the overall goals of the Mission are definitely positive. However, as this article has tried to outline, in many respects the Mission falls significantly short of expectations, and the details of the actual measures do not seem equal to its objectives. There is a decision to strengthen national health services, but this is presently significantly linked to internationally funded programmes; there is a desire to improve public health but this is mixed up with some notions of privatisation; there is a recognition of the present deep health crisis, but the response is somewhat fragmented and seems to lack an integrated, health systems approach.

Keeping this in mind, it is necessary to support and press for proper, effective and accountable implementation of the positive elements of the Mission, while critiquing and presenting alternatives regarding its negative aspects. It is with such an objective in mind that Jan Swasthya Abhiyan has decided to initiate a 'People's Rural Health Watch' which would monitor the development of Mission activities in several selected states, and at the national level, in the coming few years. By means of multi-centric surveys involving civil society organizations, JSA would assess and analyse the implementation of the Mission, and would widely disseminate the survey findings along with giving policy suggestions and alternatives, with a view to support genuine strengthening of rural Public health systems. Public health professionals and academics could definitely contribute to this process, and could thereby help strengthen rural public health, in a setting of social accountability.

Finally, History, it is said, repeats itself – the first time as tragedy, and the second time as farce. The story of ensuring health care for the rural people of India may be traced back to the Bhore Committee, which adopted the goal of Universal access to Health care for all on the eve of Indian independence. That this goal could not be achieved is obvious; and then history repeated itself for the first time a quarter of a century ago when 'Health for All' was adopted as a goal for Health development. This repetition of history ended in tragedy, with the subversion of the comprehensive Primary Health Care approach, which was replaced by a set of technological 'quick-fixes' that only scraped the surface of the problem while leaving the systemic issues unchanged. And now, History is repeating itself for the second time; again the declared goal of the Mission is "to improve the availability of and access to quality health care by people, especially

for those residing in rural areas..."[1]

If the first repeat of history ended in tragedy, what fate will NRHM, this second repetition of history, meet? While it is too early to pass judgment on this, already some ominous trends are visible, which have been outlined in this article. It should be our task as public health professionals and concerned citizens to strongly advocate for the NRHM to adopt a comprehensive approach to strengthening of public health systems, based on enhanced national resources, in a framework of accountability and rights; this could be our contribution to strengthening Health services for the people of rural India, whose striving for better health and better lives in the face of tremendous odds should be our primary inspiration.

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Need of Training for Health Professionals on National Rural Health Mission

P. K. Dutta *

Summary

Training plays a key role in health manpower development and management of health care system. Since NRHM is a new concept, due weight-age has to be given to various components of the Mission. For the efficient and effective performance of medical and paramedical workers a certain level of competence in the form of knowledge, skill and attitude are essential. Various aspects of training activities to be included in training programmes have been discussed in the paper.

Key words- NRHM, Awareness Generation, Orientation Training, ODL, IGNOU

Introduction

Recognizing the importance of health in the process of overall socio- economic development and for improving the health status of the people as well the quality of life of one billion plus population , the Government of India has launched the National Rural Health Mission (NRHM) on 12 April, 2005, to carry out the necessary architectural correction of the health care delivery system in our country. The Mission as announced by the government, is a bold attempt to bring about changes especially in 18 " high focus" states. The concept firmly believes in the decentralization of health system and reaffirms it's faith in community participation and ownership of public health. It is hoped that the Rural Health Mission and RCH –II would be operationalised in the spirit of National Population Policy (2000) and National Health Policy (2002)[1].

Training plays a key role in health manpower development and management of healthcare system. Training can be viewed as an action process by which capabilities and performances of health professionals can be improved in National Rural Health Mission in terms of knowledge, skill and attitude required for effective performance of their tasks and functions[2].

Training Aspects

Training activities for implementing the National Rural Health Mission (NRHM) aim in providing the various categories of health functionaries' necessary facilities and opportunities in acquiring knowledge develop skills and cultivate correct attitude for achieving the goals of the mission in an effective and efficient manner.

For understanding a training system, the following aspects need to be considered:

- Formulation of training objectives
- Identification of training needs
- Designing curricula and preparing course material for various categories of health functionaries
- Implementation of training programmes including skill development, and
- Pre and post evaluation of training activities to assess the impact of the training.

Objectives of Training activities

- To create awareness about various aspects of NHRM, i.e. Mission, Vision, goals, strategies, plan of action including role of ASHA, Rogi Kalyan Samiti etc to political leaders, bureaucrats, NGOs and Panchayat Raj Institution (PRI) members
- To impart knowledge and skill to various categories of health functionaries at state, district, block and village level for achieving better health status and better quality of life
- To create a separate cadre of social activists, i.e. ASHA, and to impart suitable training programme to this group

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- To design suitable curricula and prepare training materials for various categories of health professionals viz, CMOs/ DHOs, MOs at PHCs, PHN, ANMs, Male health workers/ supervisors and AWWs/ TBAs.

Identification of Training Needs

The assessment of training needs is an exercise to be undertaken before designing a training programme. Since NRHM is a new concept due weightage has to be accorded to various components of the mission. For efficient and effective performance of medical and paramedical workers a certain level of competence in the form of knowledge, skill and attitude are essential. Some time, these attributes are actually possessed by paraprofessionals but may fall short in his performance in the field. Though there is likely to be a gap between the anticipated level of competence and his actual level of performance. Therefore, while ascertaining the training needs of the health functionaries, their existing knowledge level should be assessed.

Incidentally if the training needs are not properly assessed, the training programme cannot be organised in a meaningful way. The training needs for health workers may be classified under the following headings:

- Individual vis-a- vis group needs
- Short term vis-a vis long term needs
- Formal (Institutional) vis-a- vis informal needs
- Needs which can be met by internal resources vis-a- vis external resources

Assessment of Training Needs

A proper assessment of training needs consists in finding suitable answers to the following questions:

- What kind of information, skill and attitude are to be imparted to health workers to be engaged in NRHM?
- Who are the people to be sent for training?
- What should be the duration of training?
- Where the training should be conducted?
- What are the topics to be taught?
- What are the various courses to be conducted?

In the next few paragraphs, an attempt is being made to answer the above questions.

Types, Duration, Venues & Topics to be covered

The types of training programmes including Awareness Generation Training (AGT) and Orientation Training Programmes for health professionals, duration, topics to be covered and target population/ students have been shown in Table-1.

It may be mentioned that the various aspects of NRHM should be incorporated in undergraduate and postgraduate courses in the near future. MCI could be requested to design the curriculum for the MD (PSM) and MBBS courses. Few MD (PSM) students should be attached to selected CHCs and PHCs for undertaking some research projects on planning, implementation and monitoring of NRHM activities.

Training on NRHM through Distance Education

It is well known that more than 70 per cent of India's population lives in rural areas. Even in urban areas, impact of conventional educational and health system is very limited. It has been realized that the number of training institutions for induction and refresher training (on the job training) , are not sufficient to cater to the training needs of the health workers specially located in remote areas of the country. Now, it has been well recognized that open and distance learning (ODL) can complement the conventional training courses in an effective manner. The advantage of distance education lies in the preparation of self-learning study material written in simple and student friendly language. More over with emergence of multimedia technology besides study material i.e. print modules, audio video material and computer technology are of immense value. Distance education material has very good potential for awareness generation training for NRHM for lay public and other community members. This material could also be delivered as a package through Panchayati Raj Institutions and educational institutions like schools and colleges. Educational bodies like Indira Gandhi National Open University (IGNOU) and National Open School could be involved in spreading NRHM for making a positive impact. Similarly training material could be developed for training of health functionaries for continuing education on National Rural Health Mission.

Evaluation of Training Programme

In any training programme, monitoring and evaluation form very important aspects. In the process of evaluation, attempts should be made to obtain a feedback from the trainees about the impact of training courses on the learners. The evaluation activities include the assessment of knowledge, skill and attitude of the participants who have undergone the training activities.

The evaluation process is to be conducted twice—before the commencement of the training programme i.e. Pre course evaluation as well as after the termination of the course, i.e. Post course evaluation. Comparison of the trainee's knowledge and skill between the pre- course evaluation and the post-course evaluation gives a fair idea of the impact of the training programme on the learners. If time and resources permit examinations/ tests are to be conducted for assessing the knowledge as well as skills imbibed by the participants. Besides evaluation by holding tests and practical examination, a feedback Performa may be designed for additional information about design of the course, capability of the trainers, breakup of theoretical and practical/ live demonstration classes at suitable venues etc. The evaluation processes are of great importance, specially for the first few pilot courses since suggestions received from the participants would help the trainers in modifying the course material for the future training programmes.

Conclusion

Ministry of Health & Family Welfare has launched National Rural Health Mission recently throughout the country to ensure improved primary healthcare services especially for poor women and children living in vast rural areas and urban slums. For improvement of health services, education and training of health workers play very critical role. In this article, various aspects of training activities to be included in training programmes for achieving NRHM successfully have been discussed. These include study of training needs, objectives, designing various types of courses for medical officers and paramedical workers at different levels have been suggested. These courses need to be designed by experts drawn from fields of health planning, health administration and also from field of education and training. Since open and distance learning (ODL) has emerged as an effective educational technology, this method could be well utilised for continuing education for doctors and nurses and refresher courses for other paraprofessionals. Appropriate evaluation methods have to be applied to assess the impact of the training programmes. It may be concluded that only good quality training programme will go a long way in achieving success of NRHM. It may be mentioned in this regard that professional associations like Indian Public Health Association (IPHA), Indian Association of Preventive and Social Medicine (IAPSM), Indian Association of Pediatrics (IAP), Indian Medical Association (IMA), Federation of Obstetricians & Gynecologists of India (FOGSI) etc can play major role in assisting the government in planning, implementing and monitoring the training activities associated with National Rural Health Mission.

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Table-1:Details of Training Courses[3,4,5,6,7]

No	Name of Proposed Training	Duration	Subjects to be Covered	Venue	Target Population/ Students
1.	Awareness generation program(sensitization program)	2 days	Mission and vision , goals , strategies of NRHM, importance of district and village health committee , Rog Kalyan Samiti, ASHA, Role of NGOs and PRIs	Town Hall , State training Centres including SIHFW, Social welfare institutes at State/ Dist. Level, Medical Colleges, CHCs, PHCs	Secretary level officers or equivalent, Political/community leaders, Bureaucrats, Additional / Joint Secretaries , DHS/ DDHS, School Teachers/ Panchayat Members, Social activists, NGO leaders, Volunteers etc
2.	Training of Master Trainers/ Training of Trainers (TOT)	2 weeks (12 working days)	**Core strategies** including perusal of mission documents, state of public health, Vision , Goals and Strategies, of NRHM, Plan of Action with all components of ASHA, Strengthening of CHCs/ PHCs, District and village health plan, Strengthening diseases control program, Janani Surakhsa Yojana,Rog kalyan Samiti, Integrating water, sanitation and hygiene and nutrition , RCH–II , importance of ISM etc. **Supplementary strategies** including PPP, Mainstreaming AYUSH, Reorienting medical education, Social health insurance , Social and Medical audit etc.	NIHFW , Regional Training centre e.g. IIHM HYD, , AIIHPH KOL , GIRH Gandhigram, Institute of Public Health(IPH), Poonamalee,etc. Few selected medical colleges	Faculty of SIHFW and other peripheral training Institutes/ Centres, Faculty members of few selected medical colleges.

No	Name of Proposed Training	Duration	Subjects to be Covered	Venue	Target Population/ Students
3.	Orientation Training of District level officers	6 days	Same as Core strategies as shown in serial No2(c) with emphasis on district and village health plan , medical and social audit , Role and responsibilities of NGOs and PRIs , Making of Household toilets ,Planning Implementation , Monitering and Evaluation of JSY , ASHA , IPHS etc.	SIHFW, DTCs, District Hospitals etc.	CMOs, Deputy CMOs incharge training,PHN, NGO leaders, District extension educators etc.
4.	Orientation Training at block level	5 to 6 days	Same as serial 2 and 3	SIHFW, DTC, District Hospitals ,CHCs, Selected PHCs	Training of MOs of PHCs, GPs , Social activists, Nurses, Block extension educators etc.
5.	Orientation Training of Para Professionals	5 to 6 days	Same as serial No 2 to 3	SIHFW/ DTC , CHCs , PHCs	PHN / LHV / ANM / Male health supervisors & workers
6.	Orientation Training of Frontline or grass root level workers	6days	Same as serial No 2 and 3	DTCs and peripheral training institutes like CHCs, PHCs, Sub Centres	TBAs, AWWs, VHGs
7.	Training of Accredited Social Health Activists (ASHA)	23 days (in phases)	Same as serial No 2 and 3 in brief along with explaining her role and responsibility including creating awareness, social mobilization, local health planning assist village health plan etc.	CHCs, PHCs and Sub Centres	Details being worked out at MOHW and NIHFW
8.	Orientation Training program for AYUSH practitioners, NGOs , PRIs members etc	4 to 5 days	Same as 2 and 3 in brief	CHCs , PHCs , Sub centres	Practitioners of Indian System of Medicines, NGO members and PRI Members.

* **N.B** All lectures should be participatory and interactive.
Group exercises and live demonstration should be encouraged.

The National Rural Health Mission (NRHM) : A Critical Overview

Rajib Dasgupta[1], Imrana Qadeer[2]

Summary

This paper explores the forces that led to the conceptualisation of the National Rural Health Mission (NRHM) including the role of the Common Minimum Programme and the Structural Adjustment Programme. The paper analyses the key components of the NRHM in terms of the theoretical frameworks of decentralisation, integration of programmes, primary health care, community health workers and standards.

Key Words: decentralisation, integration, primary health care, community health workers, standards.

What brought about the National Rural Health Mission (NRHM)? The defeat of the ruling alliance in the 2004 Parliamentary Elections with its discredited "India Shining" campaign and the compulsions of an alternative alliance around the Common Minimum Programme (CMP) forced the political leadership to introspect about the silent majority – India's rural population, 72.2% by the 2001 Census. The CMP pledged to strengthen the fundamentals – rural employment, health and education. Key proposed changes in the health sector included increasing budgetary allocation to 2-3% of GDP, major expenditure on primary health care and communicable diseases, health insurance for the poor and regulation of drug prices.

The NRHM proposes a complete revamp of rural health services similar to the changes following the fall of the ruling party in 1977 Parliamentary Elections; attributed to the 'excesses' of the Family Planning Programme. In 2004, it was recognised that the Structural Adjustments Programme (SAP), as practised in India, had not translated into benefits for the majority of the rural communities. Suicides of farmers added an edge of emergency and the election results were interpreted as a 'referendum' for the reforms process. Significantly, in the run-up to the elections, Civil Society Organisations (CSO), particularly the Jan Swasthya Abhiyan (JSA), had lobbied with major political parties for inclusion of health issues in their election manifestos. In the new climate of decentralised governance and stake-holder participation, members of the academia and CSO were involved in the consultative process of drawing up of the NRHM. However, neither the process of decision making nor the incorporation of recommendations was to their satisfaction even though draft proposals were modified.

Health sector reforms over the 1990s changed the notion of health care from a 'service' for all to a 'commodity' There was stagnation in the number of rural public health institutions and beds in public hospitals, with a decrease relative to population[1] and the general functioning was inefficient and inaccessible [2]. Analysis of the National Sample Survey data showed that respondent perceptions of not accessing care due to financial constraints increased from 10% to 20% in rural areas between 1986 and 1996. The rate of untreated ailments has increased for the lowest percentile below the 40th for the poorest expenditure deciles and the poor continue to resort to the public services for secondary and tertiary level care than the better off [3]. Ironically, the National Health Policy 2002[4] wanted to 'leave it (services) to the community' and the onus of provision of services is shifting to the private sector and NGOs.

The claims of the NRHM[5] include provision of effective healthcare and universal access to rural population with special focus on 18 states, architectural correction of the health system, decentralisation of programmes and population stabilisation. To what extent does the NRHM offer corrections?

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The decentralised planning model proposed in the NRHM is a positive change. Panchayats, however, are yet to encourage participation of the poorest and the marginalised. Attempts at community control through Panchayati Raj Institutions (PRIs) have been effectively countered by the technical health professionals in several states[1] and the NRHM has no strategies to handle this issue. Further, decentralised planning and inter-sectoral convergence is proposed to be attained through creation of quasi-government societies implying further withdrawal of the state. The experience with the Hospital Development Committees is that they promoted privatisation and became tools for engaging public-private partnerships. The proposed management models (Project Management Units) belong to the genre of the New Public Management that has been at the core of the reforms process [6] – a value-for-money approach to cut costs of the provider (the state) while leaving the community to access it from engaged agencies and private partners, where ironically the PRIs less controls.

The NRHM claims to integrate various ongoing national programmes. There are no intentions, however, of touching the three major diseases control programmes for Malaria, TB and AIDS that have been verticalised as a part of the Millennium Development Goals (MDG) linked to the market needs of the pharmaceutical industries. Banerji [7] has also expressed his apprehension that the National Disease Control Programmes will continue to retain their 'essential verticality' as was originally envisaged. The integrative strategies are thus limited to RCH and Family Welfare Programmes to promote fertility control and lower Maternal and Infant Mortality Rates.

The Sixth Five Year Plan envisaged three types of rural healthcare institutions, namely, a Sub-Centre (SC), a Primary Health Centre (PHC) and a Community Health Centre (CHC) as the first referral centre. The district hospitals were to function as the secondary tier for the rural health care [8]. In a significant departure, the Mission Document states that "secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units(FRUs) and the district hospitals" and also that "all the National Health Programmes (NHP) should be delivered through the CHCs". These are significant changes weakening the institution of the PHC and focusing on specialised medical care services at the CHC level; it medicalises the notion of the Primary Health Care approach. The responsibility of the NHP will be vested on the newly formed contractual position of the Public Health Programme Manager, doing away with the last vestige of integration at the level of the Medical Officer of the PHC.

With the CHC being further away for most people (than a PHC), communities will be increasingly pushed to access local practitioners (largely unqualified) or reach the CHC (or private nursing homes) with complications. Simple computations for common illnesses show that the cost of medicines for uncomplicated conditions in the open market is about 3-4 times more than what the PHC would have incurred. In case of complications, the state would be spending as much as 30 times more than the cost of primary care at the PHC. A patient accessing the private sector would be spending about 80 times more than what he would pay at the private clinic in uncomplicated illnesses. Despite claims to improve functioning of CHCs and PHCs, the Janani Suraksha Yojana proposes outsourcing of obstetric services to private obstetricians/institutions – akin to the Central Government Health Scheme (CGHS) becoming the largest consumer of corporate hospitals. These changes may meet the notion of "operationalising community health centres into functional hospitals" but greatly weakens rural primary health care – the *raison d'etre* of the Mission.

The NRHM has proposed the creation of "a new band of community based functionaries, named as Accredited Social Health Activist (ASHA)" that would be "a health activist and mobilize the community towards local health planning and increased utilization and accountability of the existing health services". However, the social and professional support from Panchayats and PHCs is not adequately envisioned. In addition, there is evidence that in the process of Health Sector Reforms, several states have toyed with similar schemes, the most notable being the Mitanin of Chattisgarh. The right to health care approach was sidelined and the state started regulating Mitanins through performance indicators[9]. The State Health Resource Centres in a typically NPM model of governance became a "para-statal body" and then a "quasi-statal body" leading to "total perversion of the

concept of the Mitanin." The philosophy of ASHA could well be corrupted by the new-age management institutions that have been envisaged, ironically, to ensure accountability and community control.

Last but not the least the NRHM has devised the Indian Public Health Standards (IPHS) for ensuring quality care in CHCs. True to its techno-centric spirit, these standards are developed only to strengthen the 'Hospital' that the CHC is to become. PHCs and SCs do not figure in this exercise. How public health monitoring will be standardised is also not stated.

What then is the Central mission? "A sharply targeted approach", focussing on women to be a vehicle for RCH II? If it was not for this why are the high fertility states being given priority? Why the promised integration of communicable disease control programmes and nutrition has been left out? And, why the gap between rural and urban poor and the rich where one gets only primary level care while the other accesses the growing private tertiary care? In the 21st century, is India offering 'world class' services for the rich and a mere ASHA (hope) for the poor?

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Need for Dedicated Focus on Urban Health within National Rural Health Mission

S. Agarwal[1], K. Sangar[2]

Summary

National Rural Health Mission represents an important public health initiative to address essential health needs of the country's underserved population. For the Mission to achieve its goals, urban population needs to be included in its scope. Urban poor population constitutes nearly a third of India's urban population and is growing at three times the national population growth rate. Health status and access of reproductive and child health services of slum dwellers are poor and comparable to the rural population. Efforts to improve the conditions of urban poor necessitate strengthening national policy and fiscal mandate, augmenting and strengthening the urban health delivery system, coordinating among multiple stakeholders, involving private sector, strengthening municipal functioning and building community capacities. National Rural Health Mission should be broadened to National Public Health Mission. This paper discusses issues pertaining to health conditions of the urban poor, present status of services, challenges and suggests options for NRHM to bridge the large gap.

Key Words: Public Health, National Rural Health Mission, Urban Health, Urban poor

Introduction

Pubic Health Initiatives for India's one billion people are aimed at mitigating disease burden and improving health. These endeavors are ongoing since the past several decades. A few notable of these include Universal Immunisation Progamme, Child Survival and Safe Motherhood Programme, Reproductive & Child Health Programme, and Integrated Child Development Scheme[1].

The National Rural Health Mission (NRHM) represents a renewal, convergence and heightening of attention to disease prevention, communicable disease control, health protection and promotion. NRHM approach reflects the growing realization among public health professionals that continued investment in clinical care brings diminishing returns and that aliments and problems addressed so successfully by public health measures in several countries and among the better-off segments of India's population, still persist in a very large proportion of our population. The NHRM provides an opportunity for health administrators to (a) provide need-based health care; (b) ensure reach of public health services to the underserved segments through vitalized health system; (c) enable socio-economically and educationally weak communities to take better care of their health; and (d) bring all pieces of the health and intricately linked sectors to function in a complementary manner to optimize impact.

While public health indicators (Under- 5 mortality, infant mortality) in India had improved measurably over the last few decades, a plateau has been observed during the last 10 years (Figure 1).

Among several factors contributing to this plateau a notable issue is that the essential public health services have remained unreachable for large segments of India's population in rural as well as in urban areas. For NRHM to achieve its goals, the growing urban population needs to be included in its scope.

Urbanization and Urban Poverty

Urban growth has been exponential in India over the last few decades. While India's rural population has doubled from 1961-2001 the urban population has grown four fold[2]. Out of the total population of 1027 million as on 1st March 2001, 742 million lived in rural areas and 285 million in urban areas. The

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percentage decadal growth of population in rural and urban areas during the decade was 17.9 and 31.2 percent respectively[2]. Population projections by the United Nations indicate that by 2030, India's urban population will grow to 576 million and constitute 40 per cent of the total population[3]. In 2001, there were 35 cities with million- plus population and 393 cities above 100,000 populations. It is estimated that the number of million plus cities in India will grow to 51 by 2011 and 75 by 2021. In addition there would be 500 large cities with population above 100,000 by 2021[3]. The Indian demographic scenario represents a 2-3-4-5 syndrome: in the last decade, as India grew at an average annual growth rate of 2%, urban India grew at 3%, mega cities at 4% and slum populations rose by 5-6%[4].

Estimates of poverty ratio in urban areas range from 67 million[5] to 90 million[6]. However, these estimates do not reflect the true magnitude of urban poverty because of "un-accounted" for, unrecognized squatter settlements and other populations residing on pavements, construction sites, fringes etc. Urban slums and other urban poor populations have remained largely un reached by the public health services[7,8,9].

Urbanization of Poverty

Poverty is no longer only a rural phenomenon. As a proportion of total poverty, the urban component has increased from 15% in the early 1970s to about 25% in the mid 1990s. In other words; one out of four poor persons of the country is now an urban resident.

Why is the urban poor population growing rapidly?

The rapid growth of slum population is contributed by: (a) Migration into a city from villages and smaller towns owing to better employment opportunities, diminution of rural agricultural land and related livelihood opportunities; (b) Natural increase in urban poor population which has a higher fertility rate than urban middle and upper class; (c) Expansion of city boundaries to include peripheral rural areas, some of which get converted into slums as erstwhile rural land is colonized for housing purposes.

Health Status of the urban poor in India

Slum dwellers in cities suffer from adverse health conditions owing to insufficient services, low awareness, and poor environment. However, the rhetoric of urban bias in development and better conditions in urban areas vis-à-vis rural areas has masked the real picture of urban poor. MCH services to the urban poor have been recognized as important thrust area by the government under the National Population Policy-2000, National Health Policy-2002, RCH II and the Tenth Five Year Plan[10]. Millennium Development Goal no. 7 (Target11) aims to significantly improve the lives of at least 100 million-slum dwellers worldwide by the year 2020. Even this very conservative target seems a tall order unless this large underserved section of population is adequately reached through public health services.

Child, infant and neonatal survival among urban poor is similar to rural population

Under-5, infant and neonatal mortality rates are considerably higher among urban poor as compared to urban averages[11] and almost as worse as their rural counterparts (Figure 2). This and other urban poor health data in this paper is based on re-analysis of NFHS- 2 data by Standard of Living Index (SLI), taking low SLI as reprehensive of urban poor. One out of ten children born among the urban poor during the year is not likely to see their fifth birthday.

High Incidence of under-nutrition among urban poor children

More than half of India's urban poor children are underweight (Figure 3). In most States, under-nutrition among urban poor children is worse than in rural areas. Survival patterns among the urban poor, clearly point at the need for extra focus on this large segment of India's population.

Access of Reproductive and Child Health Services is low among Urban Poor

The reach of essential preventive health services to the urban poor and utilization of health services by these segments is abysmally low: a) about 60% of children are not completely immunized by 1 year of age; b) use of birth spacing methods is abjectly low at 4%; c) almost 6 out of 10 babies are delivered at home in the absence of a trained health worker.

Health Conditions and Access to Services is worse in EAG States

The eight large and less developed EAG States of India constitute 32% of India's urban population and are home to 28 million urban poor[2].

In these less developed states under-5 mortality and Infant mortality among the urban poor is about 1.3 times and 1.6 times higher than their respective National figures[10]. Access to RCH services amongst urban poor is also worse than other states of the country[10].

- Institutional deliveries, among urban poor in UP are 6.5 times lesser (13.1%) than in Tamil Nadu (85.6%).
- Similarly, complete immunisation coverage among urban poor in UP is 29.7 percent compared to 74.4 in Tamil Nadu.

Poorer access to services has contributed largely to deprived health conditions of urban poor in these states.

Government Efforts for improving health of Urban Poor

Though Government efforts have been primarily rural centric, a few urban schemes have been implemented in the past. These include the Urban Family Welfare Scheme(1950), Urban Revamping Scheme(1983), Sterilization bed scheme(1964) and post partum centers(1966) in urban areas. However, the coverage of the schemes has been far from complete. The rapid growth in urban population has further eroded the coverage levels of these schemes. Recently, the World Bank funded India Population Projects (IPP- V and VIII) have attempted to provide health care services the urban poor. However, these schemes have been operational only in the mega cities like Delhi, Mumbai and Chennai.

Why do primary health services not reach the urban Poor?

Those with the greatest need for health care often have least access to it. Reach and effectiveness of maternal and child health services in urban slums are strained by several challenges.

A. Systemic Factors

The existing Urban Health Delivery System is far from adequate to respond to needs of escalating urban poor population.

1. Lack of organized public sector infrastructure and services in urban areas

Despite accounting for one-fourth of the country's poor population, urban areas have less than 4%[12] of Govt. Primary Health Care facilities – which are the most important sources for preventive services like immunization, ANC for the urban poor. With a total urban population of 285 million, the available Urban Primary Health Infrastructure translates to one health facility (Urban Family Welfare Centre / Health Post) for about 1.5-lakh urban populations. IPP-VIII and other programs operational only in selected cities did not reach all urban poor even in these cities.

Large number of urban areas has been completely left out or poorly targeted. Health Posts were established in only 10 States of the country. 32% of health posts were established in Maharashtra while the scheme remained uninitiated in Bihar. Only about 1/10th of the sterilization beds are in EAG states [12]. Staffing has also not increased in response to urban growth[13].

2. Higher allocation for Bigger Cities

There is inequitable distribution of available resources for urban poor among different cities. While, medium–small cities have significant urban population most urban programs have focused on mega cities like Mumbai, Delhi, Kolkata, and Chennai. These mega cities are preferred to other relatively smaller cities for financing since they have greater management and negotiation capacity that enables them to garner more resources[14].

It is projected that many of the presently smaller cities will join the rank of million-plus cities in the next two decades[15]. Thus preparedness in the smaller cities is needed to meet this growing challenge.

3. Poor access and utilisation despite proximity

Poor access despite proximity is a result of (a) weak demand; (b) minimal outreach services; (c) very weak community-provider linkages; (d) timings that often do not suit the daily wage earning urban poor.

Urban poor prefer home deliveries despite availability of government and private hospitals, because of concerns like unfriendly treatment at hospitals, securer environment at home, nobody to take care of other siblings at home, expensive private health care facilities.

Poor access of services is also reflective of the family having to cope with imperative issues such the risk of eviction and struggle for access to basic services like water and sanitation, all these being compounded by low health awareness.

4. Lack of sensitization among the service providers

Sense of apathy towards slum dwellers, considered an 'unnecessary intrusion' into the city, exists among service providers. Health service providers are often rough in their behaviour towards slum dwellers. This dissuades the latter from availing services.

5. Poor living environment that compounds the lack of health services

This rapid, unplanned urbanization and simultaneous growth of urban population in limited urban living spaces visibly impacts the quality of life of slum dwellers. Access to water supply and sanitation facilities among the urban poor is low. 61.7% of urban poor households do not receive piped water supply and 65.9% do not have any toilet facility[10].

When infrastructure and services are lacking, urban settlements are amongst the world's most life threatening environments. Child mortality and morbidity (diarrhea in particular) have been associated with poor water quantity and quality, lack of sanitation and poor hygiene practices[16].

Location of slums in unhygienic surroundings accentuates health adversity. Slums located adjacent to large open drains have a greater incidence of diarrhea and other water-borne diseases[17]. Slums adjacent to waste disposal sites face hazards of polluted water and air. Pigs, vultures and other animals affect levels of hygiene maintainable in a slum thereby increasing the risk of spread of infection amongst children who come in close contact with the outside environment.

B. Urban Poor Related Factors

Issues pertaining to 'urban poor' populations also pose further challenges in urban health care.

1. Illegality of slums and Social Exclusion

Slums are almost always initially informal settlements with no land tenure rights. They are considered synonymous with pockets of dirty, diseased and gloomy people and wished to disappear to make way for a clean and posh neighborhood by their upper and middle class neighbours[18]. Governments often try to relocate / demolish entire slums to 'clean up the city'. The demolition drive that left 4.5 lakh people homeless was part of Vision 2020, the government's plan to make Mumbai a "world-class" city like Shanghai[19].

Planners and service providers often harbour the perspective that providing service to 'illegal slums' implies giving them legal sanctity. In Indore, immunisation services scarcely reached non-notified slums while notified slums received benefits of repeated interventions[8]. Figure 4 shows that basic service availability in non-notified slums is half or lesser than in notified slums.

2. Large proportions of slums are invisible

Services usually do not reach hidden and missing pockets of urban poverty that are not part of official slum lists such as limestone and brick-kiln workers, construction site workers, workers of local industry (leather, jute, glass). Bound to a specific industry, they are usually on some private land, unseen by most[20].

Owing to long delays in updating of official slum list in most cities, slums may remain unrecognized for years. As an example, in Agra city, as per the list of Department of Urban Development Authority (DUDA), there were 215 slums with an estimated population of 3 lakhs. An assessment of the underserved population, conducted in 2005 for planning Agra's Urban Health Project, identified 393 slums with a population of approximately 8 lakhs[21].

3. Weak social fabric, collective negotiation capacity

Issues like illegality, social exclusion, uncertainty of land tenure, threat of eviction, and being forced to

live in a disabling environment result in a sense of resignation among slum dwellers about their surroundings and wellbeing with compromised motivation to invest in infrastructure.

Other factors like heterogeneity among slum dwellers with migrants from different villages, varied cultures, fewer extended family connections, and more women engaged in work lead to lesser willingness and fewer occasions to build urban slum community as a strong collective unit.

4. Temporary Migration and Floating Populations

Temporary migration to their native villages, especially of pregnant women for delivery results in missing out receiving services from either residence. Mother and baby do not receive services in the village due to distances, unavailability of previous record of services received and lack of awareness and negotiating capacity.

Health service delivery for floating population in urban areas is a challenge for urban health planners. Large cities and religious towns have substantial and regular inflow of floating population. Mumbai city officials estimate about 2-3 million floating population[22]. City population of Haridwar, a religious town, is virtually overrun by pilgrims on special occasions in the year particularly the Magh Mela, Baisakhi, Kanwar Mela. Pilgrims run into tens of millions, once every 6 years during Kumbh / Ardh Kumbh[23].

C. Weak Coordination among and limited capacity of Stakeholders

Weak / absent coordination among public and private urban health stakeholders

There are multiple urban health stakeholders including Health and Family Welfare Department, Integrated Child Development Scheme (ICDS), Urban Local Bodies (ULBs), Department of Urban Development Authority (DUDA), Non- Government Organizations (NGOs), Community- Based Organizations (CBOs), Donor Agencies, Professional Bodies (IMA, IPHA, IAPSM, IAP), Private practitioners, Corporates, Charitable Organisations, Employee State Insurance and local resources such as schools. These stakeholders operate in isolation with little coordination. They can benefit greatly by sharing resources, information, and expertise and avoiding duplication of efforts.

Weak municipal capacity in most states

The capacity of ULBs except in larger metropolitan cities is observed to be weak. In most of the 73 rapidly urbanizing, 2 lac to 40 lac size cities, Maternal and Child Health service delivery capacity of Municipal bodies is grossly inadequate. Most Municipal Bodies have insufficient health program management experience, which is also responsible for the underutilisation of funds available under various Central government schemes such as the National Slum Development Programme (NSDP).

D. Lack of Political and Civil Society Consciousness

Major political forces harbor a significant greater rural bias while thinking of poverty. This has resulted in most attention being paid to rural poverty while the poor in urban areas have been neglected or at best provided passing reference in government policies and programmes. An analysis of rural and urban ICDS coverage shows that one AWC to total population ratio in rural areas is 1:1260 (79%) and 1:6114 in urban areas (16%)[24]. The civil society in general also views slums with indifference.

Opportunities for impacting urban health are several

Growing Recognition of the problem and burgeoning interest: The Government has acknowledged non-availability as well as substantial under utilisation of available primary health care facilities in urban areas along with an overcrowding at secondary and tertiary care centres[25]. MCH services to urban poor have been recognized as important thrust area by the government under the National Population Policy-2000, National Health Policy-2002, RCH II and the Tenth Five Year Plan.

Resources and Potential Partners Abound: City planners and programmers can collaborate with a range of public sector and private partners: Health Dept., NGOs, Private and Charitable hospitals, ULBs amongst other to have a greater impact on health services coverage in urban slums.

Urban Poor Geographically Approachable: Seeing the glass half full or half empty; crowded living of slums makes larger number of people geographically accessible for outreach activities in lesser time unlike rural areas where population is more dispersed.

74th Constitutional Amendment, an Opportunity for City Governments: The 74th Constitutional Amendment which delegates powers and responsibilities to ULBs is a big opportunity to improve the conditions in disadvantaged urban settlements. Under the 12th Schedule of the 74th Amendment, health services are mandated as functions of ULBs. It is also in the political interest of elected representatives to utilise this opportunity and broaden the spectrum of their current activities to include health services to the urban poor. This will help better serve and nurture their constituencies.

Basic Health issues are those with which we are familiar: Technical health priorities of antenatal care, safe / clean deliveries, neonatal care, immunisation, diarrhea and ARI are all issues that public health programmers are familiar with.

Urban poor can be easily reached for communication activity: Exposure to mass media has been shown to have substantial effects on people's attitudes and behaviors in India even after controlling for urban / rural residence[26,27]. Since availability and access of mass media is higher in urban areas, urban poor can be easily reached for communication activity and are more likely to embrace change.

What can be done?

This paper suggests approaches to improve health of the Urban Poor as we move forward on the agenda of progressing towards achieving aims of the National Rural Health Mission.

Strengthen National Policy, Fiscal Mandate and Vitalize Implementation: It will be crucial to ensure an equitable rural-urban distribution when allocating resources for policies and programs aimed at improving health of the population. Existing policies need to be improved to make them more urban poor friendly, practical and measurable. Broadening the scope of the *National Rural Health Mission to unequivocally include the urban poor, and re-designating it as the National Public Health Mission merits consideration.* Energetic policy implementation can be ensured through (a) regular training of officers and (b) increasing information about various schemes to urban poor. Civil Society uproar generated from time to time will add the very helpful social push. Measures for ensuring implementation of 74th constitutional amendment and strengthening ULBs are needed.

Strengthen and Augment Urban Health Delivery System: Once the NRHM focus is expanded to include health services to the urban poor, an operational plan for strengthening urban health services will have to be put in place. There is a clear need to (a) develop, support and strengthen dedicated Public Sector Infrastructure for urban health services with special focus on preventive services for slum dwellers and (b) establish Urban Health Authority at City and State levels with clear roles, responsibilities and accountability for result based indices of the urban-poor.

To improve reach and quality of health services there is a need to (a) provide motivational training to health providers (ANMs, MOs, Supervisors) to be more sensitive towards the disadvantaged and to coordinate effectively with Community Health Volunteers and CBOs; (b) develop a delivery system that is responsive to the needs of slum dwellers and facilitates them to avail services; (c) regularize outreach services in slums; (d) Provide health card to every urban child to ensure basic health services.

Go beyond Notified slums to find the Urban Poor: The urban health component of NRHM would need to define approach to developing city level urban health plans which are responsive to the urban context where slum lists are often incomplete, urban poor clusters often show migratory trends and remain invisible. Comprehensive planning is critical to ensure that un-listed and invisible urban poor clusters or slums (which are also the neediest) are reached. Official slum lists need be regularly updated. Public health service administrators need to be sensitized that legality / notification related issues do not come in the way of reaching out to a family or a cluster with basic health services as mandated in the Indian constitution. Since urban poor populations are highly mobile and diverse an in-built flexibility will enable urban health services ensure that such population are included.

Coordinate among Multiple Stakeholders: The NRHM has mandated convergence of different sectors for optimal utilization of available resources. This aspect of the NRHM assumes greater relevance in urban areas where presence of many stakeholders is a palpable opportunity. For enhancing reach to the urban poor it is important to utilise resources from different departments / sectors. For example regular coordination meetings between various stakeholders (Health department, DUDA, Charitable organization, ICDS, Municipal Corporation, CBOs, Local representative and local resource) at ward level in Indore facilitated by a non-governmental organization have resulted in improved health services to the low-income populations[28]. Health department could collaborate with other stakeholders (water and sanitation departments) and NGOs to provide basic environmental improvements and health services in slums.

Involve Private Sector: Involving (private doctors, charitable facilities, NGOs, Corporates) for defined essential services including outreach services is a clear opportunity. Public- Private Partnership (PPP) can be an important bridge strategy for meeting the public health challenge of quickly expanding services and reaching to the under-served. Slums uncovered by health services were covered by PPP in Andhra Pradesh, Bangalore and Guwahati[29]. PPP enables use of existing Public and Private infrastructure and capacities to expand services rather than invest time in building new infrastructure-saving costs and time.

Strengthen Municipal Functioning: To pursue the mandate enshrined in the 12th schedule of the 74th Constitutional Amendment, it is essential that municipalities are equipped adequately for urban health programming, generating resources at the local level, better financial management and effectively engaging with private sector partners.

Extra focus on EAG States

NRHM has identified certain high focus States where there is a greater need for improving health services. From within these NRHM high focus states, the low performing EAG States, which are home to 43% of India's urban poor, present a special challenge of poorer health status and poor availability of services for urban disadvantaged. Program planning, implementation and monitoring capacity is far weaker than the better performing states. Municipal governance and program and fiscal capacity is also weaker than other states. These eight EAG States also present a special opportunity being eight administrative units, which have the potential to vastly expand and improve urban health, services with support and encouragement. Greater emphasis through capacity enhancement efforts, more frequent review and hand holding to these eight states will enable them reach out to a very large proportion of the country's urban poor. Pilot lead programs could be established in one or two cities in each of EAG States to serve as early learning sites as an impetus to further urban health efforts and as an impetus to advance urban health efforts.

Build Capacity of Slum Communities for Improved Utilization of Services

The NRHM outlines the need to strengthen community level capacities to improve health of the communities and the need to measure outcomes at the community level. To address low uptake of services by urban poor it is vital to a) strengthen community-provider linkages through a trained cadre of slum based health volunteers similar to the ASHA proposed in NRHM, women health groups and other appropriate strategies b) build capacity of community groups to facilitate promotion of context relevant behaviors pertaining to maternal and child health. NGOs can play a crucial role by building capacity of slum communities and thus enhance utilisation of public sector services[30].

"A stitch in time saves 9"
...we are talking of 90 million here. Can we afford to wait?

Acknowledgement

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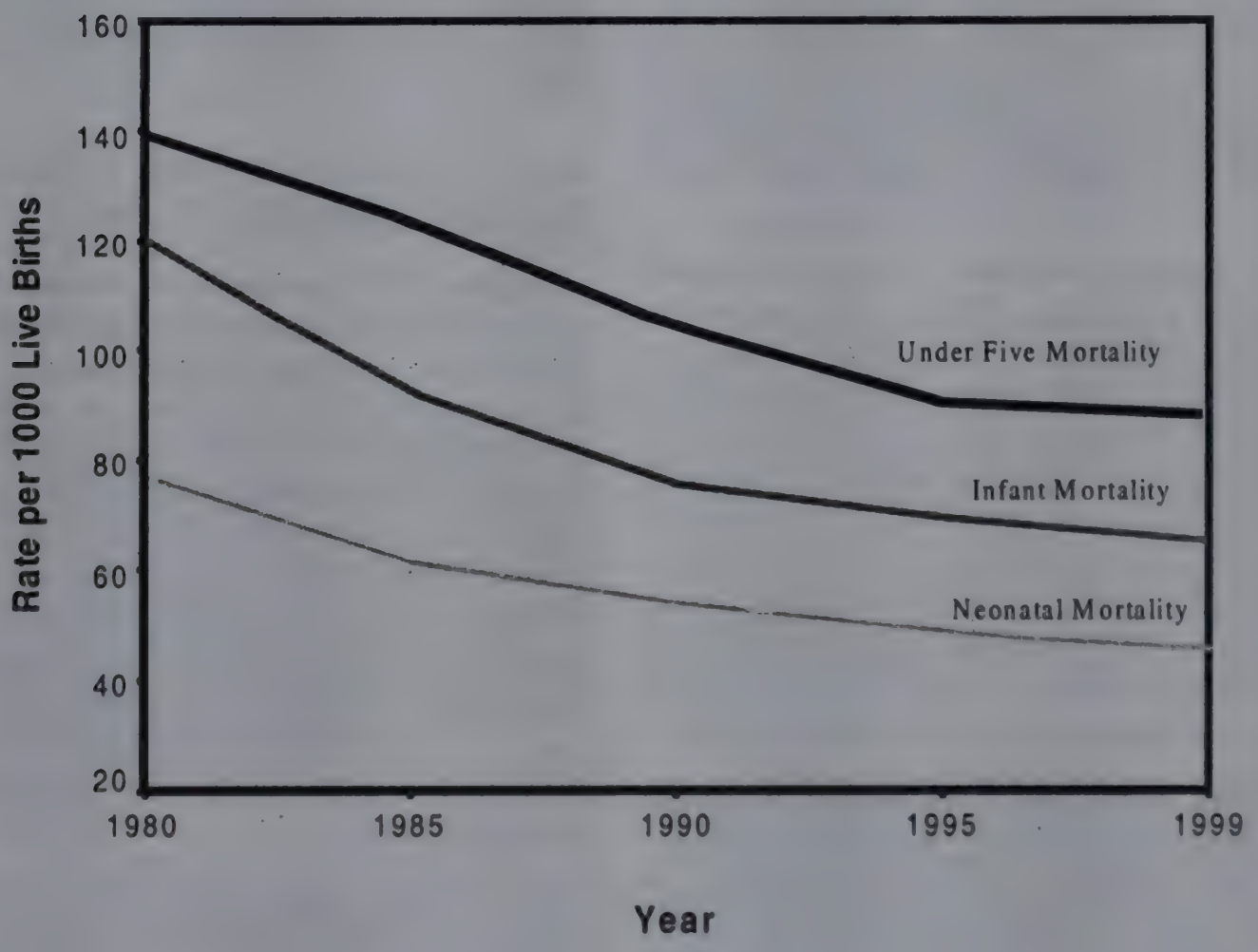
Figure 1: Recent Trends in Mortality



Source : SRS Bulletin (2002)

Figure 2: Mortality rates among Urban Poor are as worse as the rural averages

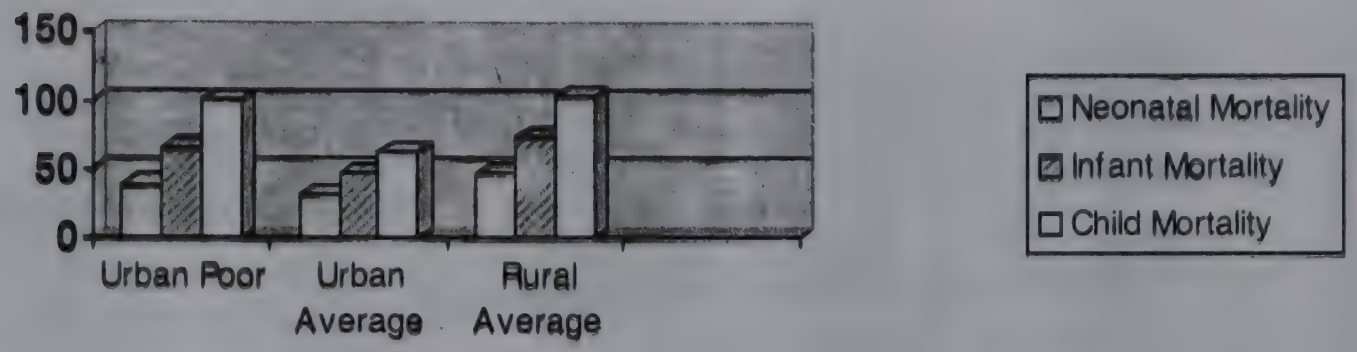


Figure 3: Nutritional Status of Urban Poor Children is worse than Rural Averages

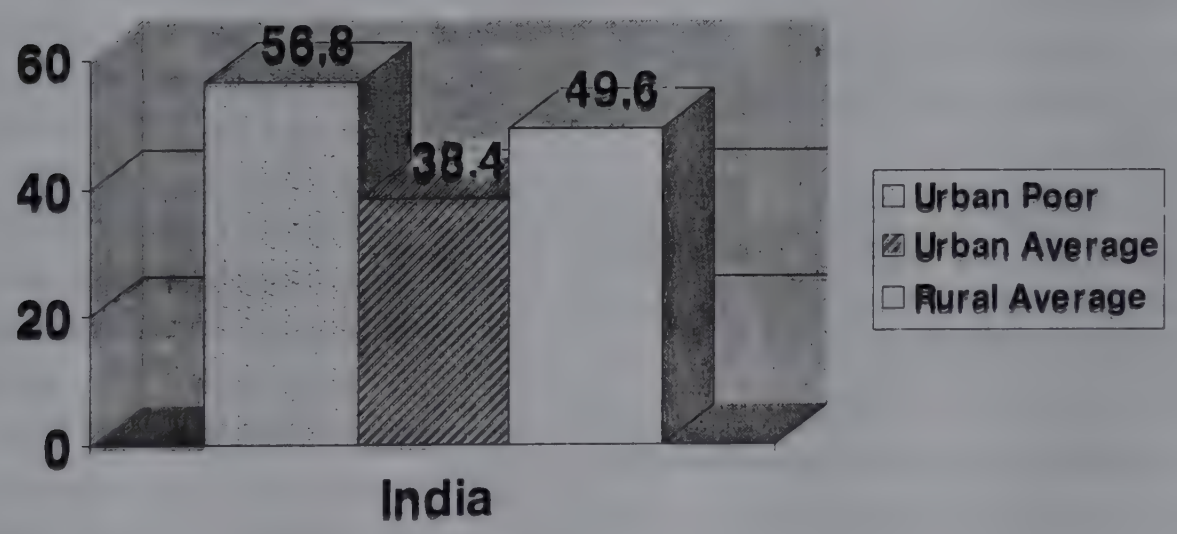
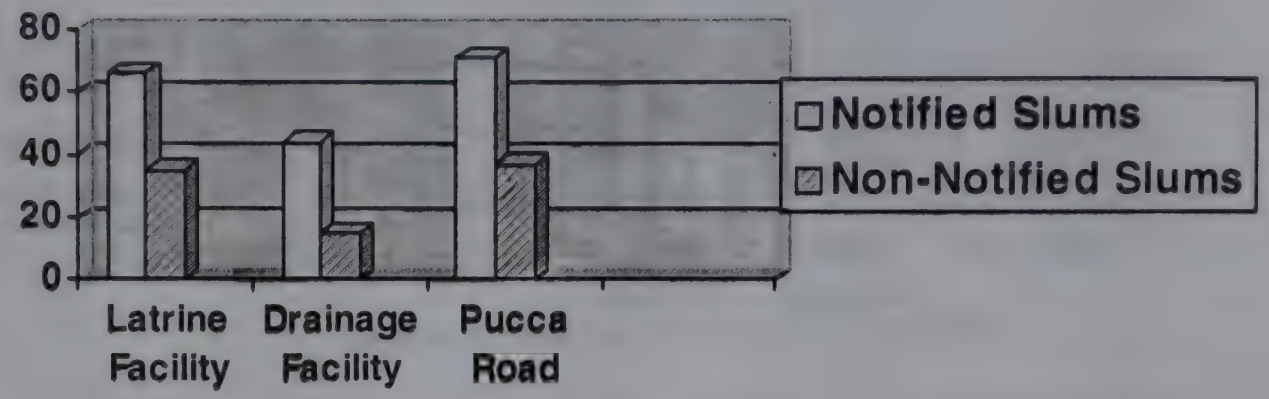


Figure 4: Availability of Basic Services in Notified vs Non-Notified Slums in India



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National Rural Health Mission - A Critical Review

D.K. Taneja*

Summary

National Rural Health Mission is strategic framework to implement the National Health Policy 2002. The scheme of Accredited Social Health Activist is an improvement over the earlier Community Health Guide Scheme. Integration of various health and family welfare programmes will result in economy and allocation of resources as per needs of the districts. Decentralised planning with the involvement of Panchayati Raj Institutions is likely to make health as people's programme. Converging water supply, sanitation, hygiene and nutrition with health planning is a logical step. The proposal to strenthen institutions of primary health care and Community Health Centres as functional Rural Hospitals alongwith introduction of Indian Public Health Standards and accountability of public health institutions to the public is likely to revolutionise the status of health care in rural India.

Key words - NRHM, ASHA, evidence based planning, PRI, SCOVA

Hon'ble Prime Minister of India has launched National Rural Health Mission (NRHM) on 12th April 2005. It seeks to provide effective health care to rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient delivery, enhancing equity and accountability and promoting decentralization.

It is a strategic framework, which provides details of strategies to be adopted to achieve major goals set in the National Health Policy 2002. It has adopted the key guidelines given in the National Health Policy 2002, e.g., equity, decentralization, involving Panchayati Raj Institutions (PRIs) and local bodies in owning primary health care management, strengthening primary health care institutions and suggestions for generating alternate sources of financing such as reimbursement for curative services at the secondary level or different types of insurance schemes. It indicates the commitment of the government to the National Health Policy as the national government has already increased its health budget from 0.9% to 1.3% of GDP, with commitment to increase it by 30% so as to achieve it to 2-3% of GDP within the Mission period. Although the Mission covers the entire country, but it rightly focuses on 18 states, which have relatively poor infrastructure. These include all the 8 Empowered Action Group (EAG) states viz. Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Uttranchal, Chhattisgarhand and Jharkhand; 8 North-Eastern states viz., Arunachal, Sikkim, Assam, Meghalya, Manipur, Mizoram, Nagaland, and Tripura; besides Jammu and Kashmir and Himachal Pradesh.

One of the key strategies under the Mission is placement of Accredited Social Health Activist (ASHA) at the village level so as to make essential health care accessible to the village people as Health Worker, Female (HWF) with coverage of 4-5 villages cannot provide the care at all times of need as well as it is not possible for her to be in touch with all the households. ASHA is envisaged to act as interphase between the government health services and the community.

The scheme is similar in concept to earlier Community Health Guide scheme launched in 1977, with a modification in 1989 that all Community Health Guides would be women. However, it takes care of many of drawbacks of earlier scheme as the current guidelines call for selection of only women candidates, who should be married and resident of the village, educated upto 8th standard against earlier 6th standard. The selection process does not rest only on Gram Panchayat but there is involvement of facilitators

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identified and orientated by Block Medical Officer. In turn they discuss it with various community groups through focus group discussions or workshops the work requirements of ASHA and prepare a panel of at least three names. This is subsequently discussed with the Gram Sabha and Gram Panchayat and a suitable person acceptable to all is selected. In addition there is another safeguard as there is no fixed honorarium but they are to be reimbursed under Janani Suraksha Yojana (JSY) or other National Programmes or Schemes based on measurable work performance.

The Mission is not a new programme but it integrates various Health &Family Welfare Programmes and converge programmes on major determinants of health in this country viz., water supply, sanitation, hygiene and nutrition. As envisaged in NRHM, it should not be operationally difficult to integrate RCH-II, RNTCP, programmes on malaria, filaria, kala azar, blindness, iodine deficiency disorders and Integrated Disease Surveillance Programme.

Integration of these programmes will result in economy by pooling of resources, increased efficiency by avoiding maintenance of separate budget lines, office staff, reports etc. It will give flexibility to the districts to provide budget consistent with the local health priorities. Supervision is also likely to be efficient and effective as district level officers can make supervisory visits to peripheral health institutions in a given sub-division for a number of programmes through a single visit instead of a programme officer covering the entire district for a single programme.

It is an established fact that interventions based on health only result in marginal improvements in the health status of the people compared to a significant difference when factors like safe water supply, sanitation, hygiene and nutrition are also simultaneously attended to. Experience has also shown that provision of safe water supply has not always resulted in its utilization for drinking purpose or decrease in water borne diseases. It has to be accompanied by education on its importance for good health and need for related hygienic practices. Under NRHM there will be joint Information, Education and Communication (IEC) by these sectors. Therefore, converging these with the health issues is a scientific step. Although as per NRHM these programmes will continue to have separate budgets and schemes. However, their implementation will be through the involvement of same mechanism of Zila Parishad and Gram Panchayat, thereby allowing for effective convergence.

Decentralisation and evidence based planning are key concepts for efficient and effective management. As per NRHM village health plan including water supply, hygiene, nutrition and sanitation will be prepared by the village Health and Sanitation Committee with the help of ASHA, the village level worker. These plans will be merged to form district plans. Devolution of financial powers and provision of financial envelop to districts and untied grant to sub-centres will help in attending to the local priorities and felt needs of people. However, the experience under RCH Programme indicates that it will take some time for these intentions are operationalised. Besides there may be conflict of interests between public health needs and the local representatives as was the case in Kerala. High quality training and orientation of representatives of PRIs and local bodies may help to overcome some of these problems.

As with any government system, Public Health System also suffers from lack of accountability and inefficiency. Monitoring of Public Health Institutions by the local representatives and social audit shall help make the health personnel accountable.

Measures like display of Citizens' Charter at all CHCs, setting up of Rogi Kalyan Samitis at CHCs with representatives of people and NGOs, appointment of ombudsmen at various levels to monitor the working of institutions and the public grievances as well as public display of beneficiaries under JSY are likely lead to transparency and proper utilization of resources.

Although vast public health infrastructure has been built up with huge expenditure on health manpower, its utilisation remains poor (less than 20% people use it in the country). This happens not only due to absenteeism and apathy of government health personnel but also due to lack of essential drugs and other supplies. The move under NRHM to ensure these supplies, provide an untied grant of Rs 10,000 to the sub-centres to meet the local requirements and involvement of Panchayats and other local bodies resulting in accountability to public would help to overcome these problems. Setting up of Indian Public

Health Standard for CHCs is a good move to assure minimum quality of services and standard procedures. This will certainly generate confidence of people in Public Health Institutions and lead to better utilization. Although, most of the norms detailed in Indian Public Health Standards have been there earlier too, either as a part of plan for Health For All 2000 AD or various health programmes but setting these, as minimum standards will exert moral pressure on the states and districts to ensure these. These standards are certainly lower than Bureau of Indian Standards for similar size hospitals but implementing latter is not practical at present as intensive inputs will be required.

As on March 2003, 3076 CHCs have been operational in the country. However, non-availability of Anaesthetists and specialists in Gynaecology and Obstetrics has been a major hurdle in operationalising these. The addition of Public Health Manager is also an important step in the right direction but how the required manpower will be available even by increasing the number of postgraduate seats in these disciplines during the limited period of NRHM, remains an unanswered question. Recruiting Social Science personnel with public health background as Public Health Managers in the face of non-availability of doctors with postgraduate qualifications in public health seems attractive. However, it will have to be observed how these personnel comprehend and implement disease surveillance and implement various disease programmes. If successful, this will provide a useful and cost effective alternative.

As the health system requires huge outlay, it is just not possible for the government to provide all the required resources. This has been the experience with National Health Service in United Kingdom as well. Therefore, alternate systems of health financing are required. The move to develop standard charges for services at CHCs is a step in right direction. It will not only generate much needed resources but also lead to accountability which is urgently required for revitalizing the system.

A number of studies have shown that hospitalised Indians on an average spend 58% of their total annual expenditure, 40% hospitalised Indians borrow heavily or sell assets to cover expenses and over 25% hospitalised Indians fall below poverty line because of hospital expenses. Thus, even in a system wherein services will be available on payment at reasonable price, there would be a need for a support system to enable poor people pay for hospitalisation. NRHM suggests community based insurance and trial of market-based schemes. How much this helps the rural poor and functions in terms of proper utilization remains to be seen. Besides, even though there is mention of government subsidy to cover a part of premiums for insurance for the poor, question remains whether those below poverty line will be able to pay the balance amounts. Alternately, NGOs or philanthropic organisations may be brought to help this cause.

With the increase in central and state budget for health, there will be a phenomenal increase in budget to states and districts. In the past, there has been the problem of not only inadequate funds but also the problem of timely utilisation and non-utilisation of funds. This has been particularly with the states, which need them, the most. The arrangement to route the central funds through State Committee on Voluntary Action (SCOVA) to District Health Societies will cut short red tape and thus reduce time delays and simplify procedures. It is a well thought measure to provide programme management support by recruiting Chartered Accountants (CAs) and Master of Business Administration (MBA), using Information Technology (IT) - based systems like e-banking. All these measures along with decentralization and empowerment of communities will absorb the enhanced funds and deliver the desired goods in time.

In the end, it can be stated that the strategies of NRHM are based on sound management principles and an attempt has been made to overcome shortcomings of similar previous schemes. In addition, there is a prerequisite to allocation of funds to states requiring signing a Memorandum of Understanding with the Government of India, stating their agreement to the policy framework of NRHM and the timeliness and performance benchmarks against identified activities. The states shall also commit to undertake systemic reform, including devolution of powers to PRIs and decentralization of the programme to district levels as envisaged under NRHM, and ensure smooth fund flow, provide technical and Management Information System (MIS) support.

For its efficient and effective implementation and realisation of set goals, the guidelines given will have to sincerely adhered to, commitments respected and vested interests resisted in the larger interest of this nation and its people. In addition, every effort will have to be made for honest and efficient use of resources allocated for defined activities.

Unfortunately, the past experience shows that socio-political situation in many of the weak performing states often does not follow these ideals right up to the peripheral level and the benefits of the schemes meant for the neediest remain inaccessible to them.

One will hope and wish that increased awareness and collective power of the people along with the detailed guidelines and safeguards provided in the Mission, NRHM will be implemented in letter and spirit to bring out a sea change in our primary health care system and benefit the disadvantaged segments of our population. If we succeed, it will set an example of **peoples' health system** for the whole world.

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National Rural Health Mission – Hopes and Fears

Concerns about Targeted Sterilisation, Retreat of the State and Privatisation

T.Sundararaman[1*], Kamlesh Jain[1], VR Raman[1], Premanjali Deepti Singh[1]

Summary

The National Rural Health Mission (NRHM), launched by the present government as part of its honouring the Common Minimum Programme (CMP) commitment, had its content shaped by an active process of dialogue between many stakeholders. This article traces the contours of the discussions on three key concerns of civil society that influenced their contributions to the shaping of the National Rural Health Mission agenda. These three concerns were promotion of targeted sterilisation, a retreat of the state from its commitments to the health sector and that the NRHM agenda would lead to privatisation of public health facilities. Whereas fears on targeted sterilisation and retreat of the state may be unrealistic, there is a thrust to increased involvement of the private sector, which needs to be understood in its entirety. There is need for continued engagement by equity concerned public health professionals and health activists at all levels of implementation and not merely community monitoring to influence and shape the National Rural Health Mission in a pro-poor direction.

Key words: National Rural Health Mission, Targeted Sterilisation, Privatisation of Health Services, civil society, public private partnerships, Health advocacy.

Introduction:

The National Rural Health Mission (NRHM) is a major undertaking by the newly elected United Progressive Alliance (UPA) government to honour its commitments under the Common Minimum Programme[1]. The political commitment to rural health and access to primary health care that the CMP articulated was itself a matter of considerable cheer. It marked a departure from a political agenda on health whose most advertised features had been the sanctioning of six AIIMS like institutions, the promotion of medical tourism and the introduction of telemedicine- all highlighted as features of an 'India Shining.'

Nevertheless the announcement of such a Mission drew a number of stakeholders into defining it almost immediately. The central health ministry itself was by then in a high level of evolution of the grand "RCH-II programme", a programme that had been carefully negotiated through with a consortium of donors- World Bank, United States Agency for International Development (USAID), European Union (EU), Department for International Development (DFID), WHO and UNICEF notably. The Ministry's immediate challenge was to absorb the energies unleashed by the announcement of the Mission without losing step in its RCH-II calendar. Meanwhile the National Advisory Committee (NAC), created as a civil society body to guide and ensure the implementation of the CMP, put forth a number of papers to define the Mission and its goals. Other than the presentations from the two secretaries, a major paper contributed by Jayprakash Narayan, editor of a well-known small newspaper influenced the discussions significantly[2]. Independent of this, the National Commission on Macroeconomics and Health had its contributions to offer and a group from the Jawaharlal Nehru University also made its separate contributions. The Prime Minister's Office and different secretaries of related departments and state departments of health were among others who actively participated and contributed to outcomes. But by far the most active entrants into the debate were a number of NGOs many of them loosely grouped into a network known as the Peoples Health Movement (or Jan Swasthya Abhiyan). This network is by no means a homogenous entity and most of its leading lights, doyens of the public health field over three decades or

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more, were to submit a profusion of independent comments and contributions that had some common threads but other wise could be quite diverse within itself. It submitted a well worked out consensus document detailing its position on various aspects of the NRHM[3].

This article selects three issues from amongst the many discussed to examine how different stakeholders with different levels of influence shaped a final document and how these influences would continue to shape implementation. Better understanding of these often contradictory pressures would help shape a stronger consensus for improving access of health care services to the rural poor and increasing public expenditure on health- the only two points on which all stakeholders were in unanimous agreement.

The Main Issues:

The three issues that this communication addresses are what have been termed "targeted sterilisations," "the retreat of the state" and the "privatisation of health services." All these were concerns that were largely highlighted by the representatives of NGOs active in the field of health. They also found resonance in the political positions of the left parties, which was one major force shaping policy on the NRHM.

Targeted Sterilisation: Then and Now

The concern that targeted sterilisation was the hidden agenda perhaps arose from the initial descriptions of the Accredited Social Health Activist (ASHA) scheme. The notion of a link worker or motivator for improving service delivery is an old idea, which periodically resurfaces. The idea was probably due for its cyclical return, and entered the debate when such a notion was highlighted by many submissions in a NAC organised workshop. By linking the creation of this worker with the CMP's mandate to prioritise health care in the 150 districts chosen on the basis of "high fertility", an apprehension was created that the central task of ASHA would be motivating women for sterilisation. The sharp protest that this drew from individuals and organisations led to clarifications and no documents had any mention of achieving sterilisation goals. However, due to the widespread perceptions imbibed over three decades of targeting, and due to the active promotion of the two child norm over a decade, there remain many active votaries of targeting within the public health system who maintain that the failure to set and monitor targets has led to a set back to the family planning programme. The issue can therefore make a comeback in the course of implementation and even in state level planning. But one would need to understand the changed context in which this issue comes back.

In the discussion about targeting one needs to note the changed context of the discussion. In its classical form, targeted sterilisation during the Emergency Period (1975 to 1977) involved overt coercion. Every employee of the government was set a target for cases to be secured, the failure to achieve which attracted penalties. The post emergency backlash convinced planners against overt coercion. However sterilisation camps continued to be the main form of achieving fertility control and getting people to come to the camps remained the major preoccupation. A series of incentives and disincentives were devised to persuade the public. However by the early nineties it was clear that achievements of targets had poor correlation with actual fertility decline outcomes. Even in the emergency period, population control in terms of fertility decline had been limited. Fertility outcomes were related more to social determinants and to outreach of maternal and child health services and the focus therefore shifted to Reproductive and Child Health (RCH) services as a whole[4].

Currently however there is changed scenario. We need to examine whether a number of unrelated factors have led to a reduction of the supply of sterilisation services. For one the shift from conventional tubectomy and its variant the mini- laprotomy to laproscopic tubectomy has meant a decline in the number of centres and specialists offering permanent sterilisation services. Laproscopic surgery takes higher qualifications, higher skills, and higher cost of equipment, more effort and expense at maintenance of equipment- all of which would act to decrease availability of this service. Conventional tubectomy continues but is not the mainstay of the approach.

Further contributing to this decline of services is the impact of a number of Supreme Court rulings in this area. Though laudable in their concern for the dignity and safety of women, the requirements of a ceiling of only 20 cases per day as well as the requirement of a minimum qualification of 500 surgeries for a laproscopic surgeon threatens to

drastically curtail the availability of services. Indeed one needs to explore whether services are maintained at current levels only by a quiet compact between authorities and service providers at the cutting edge that these rulings are "impractical" and that in public interest they may be ignored or "managed." But given the fact that professionally few surgeons enjoy doing high numbers of repetitive minor surgeries (and now one cannot claim high numbers of cases done as an achievement), professional reluctance adds in and in many places surgeons have in writing declared they would obey the laws and refuse to do more – leading to an impasse.

This reduction of public provision of services, it may be argued, is not peculiar to sterilisation services. Unmet demand is not only in the area of sterilisation services and the emphasis in official health policy of using the term unmet needs only for sterilisation services has been quite correctly critiqued. However whereas in most other services like Medical Termination of Pregnancy (MTP) services or institutional deliveries private nursing homes have risen to fill the gaps. The private sector has failed to pick up sterilisation services as an area for its expansion. And at any rate in the 150 poor achieving districts or even the priority "Empowered Action Group (EAG) states" of the NRHM, private sector presence is limited.

Meanwhile, fertility preferences have changed in favour of small families- probably related to the rather dramatic increase in female literacy in the last decade. Though unmet demand for contraceptive services is well documented, this rising demand for contraception in the face of a constricting supply of services is almost absent from published material though it is widely acknowledged at the level of field level health care providers.

Discussions with health workers whether in urban Kolkata or in rural Chhattisgarh show that there is a large number of women getting pregnant while "on the queue" waiting for the next camp to be announced and their turn to come up. Today, the target fixation and the sterilisation camp remain, not as an instrument of coercing reluctant families to undergo sterilisation, but to cajole the health system, especially the specialist who does the procedure, into a minimum level of provisioning of these services. And even in this form this targeting remains undesirable because of the high attendant risks of poor quality services in large sporadic camps. Incentives for the client remains- more as a way of getting expenditure levels achieved easily and often allegedly providing much motivation to health care providers- certainly more than to beneficiaries. Disincentives, especially the two-child norm remains in most states. These are most visibly and actively implemented by district administrations in panchayat elections where they mainly serve to disqualify mostly women of weaker sections in an attempt to undo some of the gains of the 73rd and 74th amendments. Their impact on fertility control is unknown and there is even little expectation of it to have such an impact. Health departments do not drive this two-child norm forward, though like the insertion of a two-child clause in the design of the Janani Suraksha Yojana shows they are not averse to using it either[5]. The third childbirth is ineligible for maternity benefit unless sterilisation is agreed on and fourth child onwards no benefits can be given. There is even a stricture in Janini Suraksha Yojana against giving maternity benefit to a woman below 19 years delivering a child. Nevertheless we argue that these are anomalies – and do not define the rule.

It is interesting to note that these concerns of failing sterilisation services were poorly articulated in the discussions leading up to the NRHM documents. Given the fact that estimates in some state RCH programme plans are projecting that only about one in three of existing demand for such services is being met, civil society needs to much more consciously build the provision of *routine*, *good quality*, *safe* sterilisation services into their dialogue on the issues of targeted sterilisation services. Unmet demand in contraception is not a new concept; only it has acquired a new urgency. The frontier in health advocacy is to demonstrate and convince the health planner and decision maker that achieving adequate delivery of these services would be possible only as part of comprehensive and effective block level hospital functioning where two or more doctors are trained to provide these services as part of a routine weekly schedule- not as part of a series of camps being conducted by a select workforce of specially created laproscopic surgeons.

Retreat of the State

The concern about the retreat of the state is based on ideological readings of the context of the Mission. This issue did not figure in any discussion where the government was present but would be one of the main

issues under debate in all other civil society consultations amongst themselves. Since the nineties, the Structural Adjustment Reforms being spearheaded by the International Financial Institutions – World Bank, International Monetary Fund (IMF) and the World Trade Organisation – have been calling for policies that have been referred to in popular discourse as LPG policies- Liberalisation, Privatisation and Globalisation policies. These refer to a set of policies based on the neo-liberal worldview that growth and development were best left to the play of market forces- with the state playing a minimal role. In such a perspective, to achieve growth the key structural adjustments are globalisation – referring to policies that enable the free movement of commodities and capital across national borders, *liberalisation* – the withdrawal of government regulations that shaped investments and trade polices so as to eliminate all control on private capital and its growth and *privatisation* of the economy- so as to provide more avenues for private capital investment and presumably a competition linked improved efficiency of public services that were hitherto state provided.

The argument put forth for interpreting NRHM as retreat of the state was that since the main economic understanding of successive governments since 1990 has always held allegiance to this structural adjustment process and the UPA is no exception to this. Recent policy developments including the National Rural Health Mission must also be seen in this light. More so because the RCH-II package negotiated with the Donor Consortium is de facto the main financial and programmatic instrument of the NRHM.

This argument needs to be examined at two levels. How central is the retreat of the state in the structural adjustment process and secondly what is the extent to which current policy making is able to depart from the continuity of the past in the health sector.

In the very first articulation of the role of health systems in the structural adjustment programme by the World Bank, public health system was defined as a safety net[6], to help limit public dissatisfaction with the adverse human effects of structural adjustment. The 1993, World Bank Report –"Investing in Health" described investments in health as one of the most legitimate and acceptable ways of transfer of resources to the poor and further argued that health is an area of market externality and a public good that market forces alone would be unable to cover[7]. It thus described public health as one of the core areas of World Bank lending. This same trend is captured in the influential report of the International Commission on Macroeconomics and Health chaired by Jeffrey Sachs, in which the current Prime Minister Dr. Manmohan Singh was a member[8]. To this committee investing in health is the main form of poverty reduction. In short, to this major strand of international economic and political policy making through structural adjustment calls for a general retreat of the state, the health sector is the most honourable exception. This is not surprising if we consider that for Organisation for Economic Co-operation and Development (OECD) countries, the share of public expenditure on health to total expenditure on health as a percent stands at 75% and if we exclude the USA it rises to a 90% share. Even the USA with a 44% public share has well over twice the Indian levels[9]. Thus, even in capitalist economies that proclaim higher income differentials as a virtue and non- interference by the state in the economic field as a necessity, a strong involvement in the health sector especially in providing services to the poor has been central to the "legitimisation of the state." To elaborate this phrase- the state needs to appear in public perception as expressing the interests of all people and the state cannot play its role in governance if it becomes perceived as only serving the interests of the rich and the privileged. The World Bank itself states with some degree of pride that its involvement in health policy and health investments has favourably altered the public perception of the Bank from that of an "uncaring bully" to one where it now "presents a more compassionate face." [10] Thus, retreat of the state in the health sector is not central to structural adjustment policies though it may apply to every other sector. In India, donor agencies have been particular about upward revision of state allocations to health sector. This has even been imposed as a conditionality of loans and grants expressing a concern of their constituencies back home that donor contributions should lead to absolute increases in public health spending and that grants in aid do not merely unlock the third world countries' internal budgetary resources for use in other sectors like defence. But mainly it is a direct construct of the donor nations own perceptions of the state's role in health care. The NRHM's central and leading commitment to increase public spending on health care from 0.9% of the GDP to 2% to 3% of the GDP[11] is therefore a serious statement - made with full concurrence of every donor

establishment- and despite the imminent failure to achieve it, should be seen as contradicting any simplistic understanding of the NRHM as a retreat of the state.

Does the NRHM represent or have the potential to break the health sector policies of the last decade? The CMP represents a negotiation between many diverse political trends- common to which is an understanding that some pro poor measures should be visibly achieved in the present term. Underlying this is the recognition that the interpretation of reforms that previous government took was fraught with adverse electoral political consequences. Therefore even to those who would accept globalisation as inevitable or desirable, the need to show pro-poor developments in social policy has acquired a sharper focus. And for those political forces, especially of the Left, that would oppose structural adjustment, there is new opportunity to carry forward new policies at least on a number of reform issues like health where a political consensus exists. Any interpretation of NRHM as a mere carry forward of already existing policies and another manifestation of retreat of the state is therefore mechanical, diverts attention from the central problems of this period- the failure of the health sector to absorb the limited funds allotted to it - and misses the opportunity to engage in negotiating for a more viable road map to attaining universal primary health care. On the other hand, the failure of the health sector to absorb funds allotted to it indicates serious problems of governance that are inherently more difficult to define and intractable in solution and therefore need much more interdisciplinary scholarship and consensus building to address effectively. The debates to date seem to have largely missed out on these basic issues of governance.

Privatisation or Involvement of the Private Sector– A Jan Swasthya Abhiyan Consensus:

On the issue of the role of the private sector, different groups had sharply demarcated understandings. The RCH-II and the donor community had already identified public private partnerships as a major innovation that needs to be made to improve access. The most important stated reason was that the private sector accounts for the major part of health care provision but it needs to be held accountable and to be utilised for public health goals as well. Repeatedly stated commitments by number of states and the centre to draw up a policy framework for public- private partnerships (PPPs) to achieve this goal has resulted so far in a listing of the various forms of PPP possible but not much beyond that. Many states had initiated different experiments in such partnership – most of which on closer examination are some flexibilities in the way some areas of hospital or public health activities are managed using non- governmental organisations, to close a few gaps here and there. Civil society opinion on public private partnership and even on involvement of the private sector was sharply divided. One important trend of thought in the National Advisory Committee came up with a strong recommendation of health insurance and of involvement of the private sector through partnerships. This trend also saw ASHA as a user fee charging extension of the private system that would be backed up by private sector hospitals in addition to public sector hospitals. Another, more extreme variant of this trend, looks to training the informal unqualified private practitioner (also known as the RMP- who is neither registered nor medical but certainly a practitioner) as the major form of rural health care provision- and a direct link from such a practitioner to a good quality hospital as the desirable model. Within the Jan Swasthya Abhiyan the positions varied from a sweeping rejection of all forms of private participation – including even contracting in of specialists into a public health facility as evidences of privatisation - to positions that would welcome private participation within a well defined set of conditions. The official Jan Swasthya Abhiyan consensus position that was agreed upon called for a cautious engagement with the issue of involving the private sector and was articulated thus.[3]

1. " The need to involve the private sector in the provision of the affordable services for the poor and to contribute to national health goals is appreciated. But there are some important concerns to be addressed before this becomes policy.
2. The flourishing unregulated and illegal sector (often called the informal sector or RMPs), is symptomatic of the break down of the health care system and this must not be projected as the solution to rural health problems- much less equated with the private sector in health and as a structure that needs only training and accrediting

for integrating into the health system. Recognising that this informal sector exists because people have no where else to go and also noting that it reduces sharply in extent once qualified service of even moderate quality becomes available, there is no need to actively proscribe and punish the informal practitioner (as demanded by the Indian Medical Association). However, we note that their continuation depends so closely on the mystified doctor – disease-drug perception of health care that they have become one of the main means of propagation of a wrong perception of health in the public and actively contribute to poverty by a wasteful consumption of unnecessary health goods. In the context of a large CHW programme, a strengthened sub-centre and a PHC and CHC structure made functional, there would be no need to invest in this informal structure, which by its very nature would be impossible to regulate and is now a pivot of all wasteful and wrong notions of health care.

3. The formal " qualified " private sector is also almost completely unregulated- in pricing of services, in quality of services and in ethics. A regulatory mechanism in place would be mandatory before public private partnerships can be forged. We note that the National Human Rights Commission has also called for such regulatory mechanisms to come into force.

4. The experience of private provisioning and public funding of services is limited and problematic. Most of the deals have had poor transparency and no public scrutiny. They have required considerable public investments in private hands with poor access to the poor in return. The cost benefits and cost effectiveness of such options have not been worked out. There are no social insurance programmes reaching out to the poor to which private provisioning and public funding of the programme may be linked and in its absence reimbursement alone would prove too costly. A national policy framework for engaging the private sector, incorporating regulation of the private health sector, and with safeguards against such initiatives becoming avenues for expanding misgovernance, must be drawn up and scrutinised by thorough public debate before it is finalised."

Conclusion: New frontiers for health advocacy:

In the complex play of factors discussed above we note different often-contradictory trends shaping the public health policy. These influences are not limited to shaping the documents of the Mission. They would have even more influence on the way these documents are interpreted, funded and implemented.

By understanding clearly the main concerns at this point of time and differentiating it from other less immediate or even less real concerns, public opinion and more important civil society participation can contribute to reshaping policies.

In our contention, targeted sterilisation is not an issue, appearing only as an anomaly or in a revised context where targeting is done to drive a hard pressed public health workforce to meet the existing public demand and not to drive a reluctant public to meet an underutilised service provision. Nor is there any evidence in the run up to the NRHM of a state trying to retreat in the health sector - though as the CMP implementation extends to more and more areas (employment guarantee scheme for example) requiring more and more public spending, unless there is the political will to raise resources and the will to address serious issues of governance, the promised tripling of budgetary allocation may never materialize. In the area of defining the role of the private sector there is a need to differentiate between different forms of involvement or partnership and note that all forms of involvement cannot be equated with privatisation or retreat of the state. Some forms of private sector involvement, if successfully implemented, would actually call for an increase of the states role and a much larger budgetary allocation. The central issue in this perspective is not really the choice between public provisioning with public funding or private provisioning with public funding– an issue that can be better decided on the merits of specific situations and contexts and economic and financial assessments. The central issue is really the problems of governance that has led to such poor results in the public provisioning approach and which would equally threaten the private provisioning with public funding approach.

The frontier in health advocacy must now shift to developing comprehensive indicators of good governance in the health sector and linking funding

policies to these. Community oversight should have the ability to go beyond documenting failures of service delivery to understanding, regulating and intervening in governance related issues that lie behind these failures. For initiating a public discussion, we would tentatively propose a set of conditions that any model of private sector involvement must fulfil to gain acceptance as a replicable and equity sensitive approach to involving the private sector:

a) There must be demonstrable, verifiable increased access to the poor.

b) There must be a guarantee of a basic minimum quality of care that is periodically verified.

c) There must be the attraction of private investment into health systems- not a transfer of public fund into private corpus.

d) The partnership must represent additionality over existing services- not merely the diversion of existing public sector clientele into the private sector or any other form of substitution of the existing public sector.

e) There must be adequate systems for monitoring three dimensions of such partnership– quality of care, the truthfulness of reimbursement claims and the access to the poor- and such monitoring mechanisms must be reasonably secured from vested pressures.

f) The reimbursments/support made to the private clinic for the management of the poor must be made with promptness, efficiency and with dignity – so that the ethical small time players have an equal if not better chance of survival.

g) That this should be seen as the first step towards gradually moving to an effective regulatory system for private health care (of course with public health care also coming under the system of regulation.)

Clearly those involved in health advocacy for universal health care have difficult choices to make. But then these are difficult times.

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Challenges of Maternal Mortality Reduction and opportunities under National Rural Health Mission - A Critical Appraisal

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Summary

Maternal Mortality Ratio (MMR) continues to remain high in our country without showing any declining trend over a period of two decades. The proportions of maternal deaths contributed by direct obstetric causes have also remained more or less the same in rural areas. There is a strong need to improve coverage of antenatal care, promote institutional deliveries and provide emergency obstetric care. Delays occur in seeking care for obstetric complications and levels of 'met obstetric need' continue to be low in many parts of the country. Most of the First Referral Units (FRUs) and CHCs function at sub-optimal level in the country.

National Rural Health Mission (NRHM) offers institutional mechanism and strategic options to reduce high MMR. 'Janani Suraksha Yojna', strengthening of CHCs (as per Indian Public Health standards) to offer 24 hours quality services including that of anesthetists and Accredited Social Health Activist (ASHA) are important proposals in this regard. District Health Mission can play an important role in monitoring maternal deaths occurring in hospitals or in community and thus create a social momentum to prevent and reduce maternal deaths. NRHM, however, depends largely on Panchayati Raj Institutions for effective implementation of proposed interventions and utilization of resources. In most parts of our country, State Governments have not empowered PRIs with real devolution of power. Therefore, much needs to be done locally to build the capacity of PRIs and develop state-specific guidelines in operational terms to implement interventions under NRHM for reducing maternal mortality ratio.

Key words: NRHM, MMR, Maternal complication, Janani suraksha, Social movement

Introduction:

India accounts for nearly 20% of the global burden of both maternal and child deaths. Approximately, 30 million women experience pregnancy and 27 million have a live birth each year. Of these, 136,000 maternal deaths occur annually. The maternal mortality ratio in India is estimated to be 400-450 maternal deaths per 100,000 live births, while the figure rises to 619 per 100,000 in rural areas. Of different states in India, Uttar Pradesh has the highest maternal mortality ratios of 720 per 100,000 live births followed by Rajasthan (640/1000 live births)[1, 2]. Direct Obstetric causes (obstructed labour, hemorrhage, septic abortion, eclampsia) account for more than 70% of maternal deaths in our country. It is embarrassing to note that a large number of direct obstetric causes of maternal deaths are preventable but the proportion of maternal deaths due to direct obstetric causes have remained unchanged over a period of last two decades.[3]

National Rural Health Mission (NRHM) is the most recent and conceptually comprehensive approach launched by the Government of India to improve the health situation of people[4]. Reduction of Maternal Mortality Ratio is an important goal of NRHM. It is interesting to note that the NRHM has core strategic components to promote institutional deliveries and comprehensive emergency obstetric care that are essential interventions for reduction of maternal mortality. The NRHM, however, is not very specific and clear on issues related to operationalisation of these strategic options and concepts. Health care models adopted in post-independent India relied heavily on mere expansion of health care infrastructure in terms of Primary Health Centres (PHCs),

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Community Health Centres (CHCs) and sub-centres to extend the outreach of Maternal and Child Health (MCH) care in rural areas. These health care centres remain poorly supervised and have not been duly supported by curative and referral care units. Therefore, they could only address, to a limited extent, the preventive and promotive health care needs of the population. Infant and Child Mortality Rates did show a declining trend during the decades of 1980s and early 1990s but the maternal mortality ratio continued to remain unchanged and unacceptably high. The pace of decline of IMR, especially Neonatal Mortality Rate (NMR) has also slowed down during the period 1995-2005. Introduction of Child Survival and Safe Motherhood programme (CSSM) in 1992 and Reproductive and Child Health (RCH) in 1997 by the Government of India marked a 'paradigm-shift' in provision of MCH care. But, these attempts could only produce limited results in absence of sustained political commitments, clear implementation strategies and supportive supervision especially for RCH (Phase I) programme. CSSM programme unfortunately did not get time to show results and got subsumed in the RCH programme. We understand now that RCH (Phase II) will be subsumed by the NRHM and implemented within the framework of its recommended institutional set-up, strategic guidelines and resources.

Integration of ongoing vertical or selective health intervention programmes and convergence of different sectoral programmes with common objectives to strengthen basic health services are laudable concepts of health management and development administration. However, in practical terms, our attempts to move from 'Principles to Practices' and operationalize these concepts have not always been successful. Examples of integrating Unipurpose worker scheme into Multipurpose worker scheme (in 1973 integrating Family-Welfare progarmme into Maternal and Child Health Programme (in 1974), integrating National Malaria Eradication Programme into the basic health services (in 1960s) sufficiently bear this out[5].

We therefore, need to carefully examine the institutional framework, resources and strategic options made available under NRHM to address the daunting challenge posed by unacceptable and high levels of MMR.

Challenges of High MMR and Strategic Options under NRHM

Challenges of MMR

Universalizing Maternal Care - Life threatening complications of pregnancy and child birth cannot be predicted with certainty and can occur in women considered 'Low-risk' by traditional criteria. Hence, the need to universalize coverage of quality ante-natal care has sound epidemiological basis and is strongly recommended. The coverage and quality of ante-natal and post natal care in different parts of our country, especially in focus states (NRHM has focus on 18 states) leave much to be desired. As per NFHS-II (1998-99) only 15% women receive full antenatal care. Only 27% of women underwent post natal check-ups. As per RCH-I Survey (2002-03) full antenatal care provided to pregnant women ranged between 44.8% (India) to 28.3% (Rajasthan). Similarly, coverage of institutional deliveries was also found to be low (39.8% for India and 28.3% for Rajasthan)[6]. In rural areas, about 75% of births take place at home. As a result, many deaths occur from complications during pregnancy, at the time of delivery or after delivery – such as hemorrhage, pregnancy induced hypertension (eclampsia), obstructed labour, sepsis and severe anaemia.

Met Obstetric need - 'Met Obstetric need' is determined by the proportion of women with obstetric complications who actually get required institutional care. It has been shown globally that 15% of deliveries turn out to be complicated and require skilled obstetric care (surgical intervention and or blood transfusion). Such facilities are made available at the sub-district level under CSSM and RCH programme (by equipping sub districts hospitals and/or Community Health Centres) in terms of First Referral Units (FRUs). A large majority of these FRUs are not fully operational and utilized[7]. A study of a national Sample of Community Health Centres (CHC) by the Programme Evaluation Organization (PEO) of the Planning Commission, Government of India (1977) has revealed that virtually none of them is working at its optimal level[8]. With regard to 'met obstetric needs', our FRUs studies indicate that only1.5% to 8% of complicated pregnancies and deliveries could reach hospitals[7]. We also notice that merely operationalising FRUs with

trained manpower and equipments need not necessarily lead to improved utilization by patients. Knowledge and faith of people regarding location of FRUs and quality of care offered are important considerations in this regard.

Delays in Seeking Care – Delays in accessing specialized maternal care happen at all levels, starting from family when relatives of the patient do not know 'when and where' to refer the case with obstetric complication (type I delay). Next, time is unduly lost in organizing transport to shift the patient to a referral hospital (type II delay). Even after reaching the hospital or FRU there may be delay in administering standard treatment to patient by hospital authorities (type III delay)[9]. Type I delay occurs because of lack of knowledge regarding pregnancy and its complication on part of care-givers and decision makers at family level. Type III delay primarily reflects indifferent and insensitive attitude of care providers in hospital besides indicating deficient facilities and manpower skills available in that hospital.

Strategic Options under NRHM

Janani Suraksha Yojna (JSY) is proposed to promote Safe Motherhood and to improve institutional delivery. The scheme is 100% centrally sponsored and provides cash assistance linked to institutional delivery for 'Below Poverty Line' (BPL) pregnant women in both urban and rural areas. The scheme covers women aged 19 years or above up to two live births and is extendable to third live birth, if it is followed by sterilization. Cash assistance of Rs.700/600 to mother and Rs.600/200 to ASHA in rural/urban area is provided. Also, assistance of Rs.1500/- is permissible for hiring expert for Cesarean Section delivery. Imprest money of Rs.5000/- is placed with ANM/ASHA to arrange transportation and other logistics. Thus, JSY has definite provisions to improve institutional delivery coverage and referral transport for seeking emergency obstetric care. It may be pointed out that cash support to hire services of specialists and for organizing transport for pregnant women with complication or requiring institutional delivery was made available under RCH (Phase I) programme. Provisions under these schemes remain grossly under utilized. In Rajasthan, for example, under the 'Referral Transport Scheme' a sum of Rs.70.8 lakhs was released to 19 districts for providing referral transport to pregnant women of poor families for emergency obstetric care. A sum of Rs.12.5 lakhs (17.6%) only could be spent for the purpose[10]. Elected representatives of Panchayati Raj Institution (PRIs) were supposed to disburse the funds and facilitate smooth functioning of the 'Referral Transport Scheme'. PRI members seem to have evinced very less interest in the scheme. Besides, knowledge about the scheme amongst potential users played an important role in its usage. Under JSY however, the funds are placed under the disposal of ANM/ASHA. This may facilitate easy access of funds needed for referral transport by potential users. Massive efforts are needed to inform the community about this scheme and thus, encourage and empower them to utilize the available benefits.

JSY, thus holds promise to effectively address the issue of high maternal mortality by promoting coverage of institutional deliveries. However, the scheme is applicable to pregnancies occurring at the age of 19 years or above and upto the second live birth, extendable to third live birth if followed by sterilization. The scheme thus covers the so called 'low-risk' pregnancies. It is well known that pregnancies occurring before 18 years of age and in grand-multipara women are 'high-risk' and need specialized obstetric care in an Institution. Such obstetric cases if not attended in an institution carry high risk of death and should be included under JSY.

Accredited Social Health Activist (ASHA) is an important aspect of NRHM serving as a link between community and the services offered by subcentre through ANM. NRHM proposes every village to have a female community health activist (ASHA) chosen by and accountable to Panchayats. Besides performing other health activities ASHA will support ANM to extend the outreach of MCH care and improve referral of routine and complicated obstetric cases to hospitals[4]. This should help in reduction of maternal mortality. However, a few important issues related to functioning of ASHA in a village need consideration.

ASHA is to be chosen by and accountable to the local Panchayat. There is a strong need to build the capacity of Panchayati Raj Institutions (PRIs) to manage social-sector programmes like health, nutrition and education. The nature of power-structure and class-caste equation in a village greatly influence the

selection of PRI members and their decisions. The process of selection and supervision of ASHA can thus get adversely affected defeating the very purpose and social objectives to be served by this "Health Activist" (ASHA). The failure of 'Referral Transport Scheme' under RCH phase I in Rajasthan was on account of in different attitude and lack of interest of Panchayat members in the scheme.

ASHA is supposed to collaborate with ICDS worker (Anganwadi worker-AWW) who plays an important role in registration and follow-up of pregnant women and infants in villages covered by the ICDS (Anganwadi centre). AWW supports conduction of immunization/maternal health and nutrition session for pregnant women and children and referral transport for identified cases. In a state like Rajasthan, the Department of Women and Child Development has appointed an additional cadre of worker called 'Sahyoginis' to improve family based health and nutrition care of pregnant women and children. Already, about 20,000 such workers have been appointed to complement the services of AWW and improve outreach of services of ICDS centres. Sahyoginis can very well perform the tasks of ASHA and thus, the need to have additional worker for the village may be avoided.

Strengthening Public Health Infrastructure - This is the most important strategic component of NRHM to reduce maternal mortality. Operationalising all existing community Health Centres (30-50 beds) as 24 hours First Referral Unit (FRU) including posting of anesthetists is a definite step proposed under NRHM to address the daunting challenge of high maternal mortality in rural areas of the country. NRHM also proposes to evolve and apply Indian Public Health standards to ensure acceptable and defined levels of infrastructure and quality of treatment offered by CHCs and PHCs. Following concerns need to be addressed while we reiterate our commitments under NRHM to upgrade these CHCs and PHCs.

- The standard treatment protocols to be adopted to deal with obstetric emergencies or other common emergencies (surgical or medical) are yet to be developed. This is an urgent and important assignment to be completed by expert group identified by the NRHM.
- Health sector is a human-resource intensive sector and must have a Human Resource Policy to build capacities of workers and offer career opportunities. Rationalization of health manpower to ensure just and equitable distribution for managing health facilities at various levels is long overdue. This is an important pre-condition for effective and sustained functioning of FRUs/CHCs located in remote districts.
- Merely operationalizing CHC/FRUs by providing equipments and skilled manpower does not ensure optimum utilization of the facility by the community. Knowledge and faith of people about location, contents and quality of care offered by FRUs are important factors determining extent of utilization of such facilities.

Institutional mechanisms under NRHM are based on Panchayati Raj System and derive inspiration from various provisions and amendments (73rd and 74th) of our Constitution meant to empower and energize the PRIs. In most states of our country Panchayati Raj Institutions are weak. In spite of requirements under the Constitution, many state governments are reluctant to devolve funds, functions and functionaries to PRIs. On the other hand, there is a strong need to build the capacity of PRIs to enable them to implement and supervise social sector programmes (Health, Education and Nutrition) in rural areas. The NRHM proposes that under the leadership of Zila Parishad, 'District Health Mission' should be set up to manage and integrate all vertical health programmes including family welfare, and Total Sanitation Campaign (TSC) being run at different levels in the district. However, in many states we find 'District Water and Sanitation Mission' already set up under the guidance of Zila Parishad to manage drinking water and sanitation activities under 'Swajaldhara' scheme and 'Total Sanitation Campaign' in the district. The roles, responsibilities and working relationships between 'District Health Mission' and 'District Water and Sanitation Mission' need to be specified.

It is logical to visualize District Health Mission (DHM) focusing more on integrating and improving the coverage and quality of Public Health programmes in the district with special emphasis on MCH services.

DHM should also create a social momentum to prevent maternal deaths and improve institutional deliveries. Maternal deaths occurring in district hospitals or at home should be reviewed to identify factors leading to death and extent to which these could be avoided. District Health Mission must assume this responsibility and impress upon the district Health authorities to conduct regular review of maternal deaths taking place in the community or different health institutions of the district. This will go a long way to transform the problem of high MMR that has remained a grave but silent emergency into a loud and clear warning requiring urgent public attention.

Conclusions

The stagnating high levels of maternal mortality ratio in our country pose a daunting challenge to all those involved in Public Health and Development programmes. Direct obstetric causes still account for a large proportion of maternal deaths. Maternal care offered in the community remains poor in terms of its coverage and quality. Poor referrals and lack of knowledge about location and services of FRUs are responsible for low levels of' 'met obstetric need'. NRHM offers opportunities and strategic options to reduce high levels of MMR. However, implementation of proposed interventions and support require an effective and empowered Panchayati Raj System which is yet to be realized in most states of our country. Therefore, much needs to be done to build capacity of PRIs and create an enabling environment to operationalise concepts and proposals of NRHM to reduce maternal mortality.

Note: The contents of the paper do not necessarily represent the policies or the views of UNICEF.

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National Rural Health Mission – "Rhetoric or Reality"

Deoki Nandan*

Summary

National Rural Health Mission (NRHM) launched by Government of India holds great hopes and promises to serve the deprived and underserved communities of rural areas. The backbone of the programme is Accredited Social Health Activist (ASHA), which will play major role in the implementation of the programme. The invariable existence of socio-cultural clusters in the community has always been a major challenge to the health care efforts made by the government. Though ASHA is a novel concept to melt the ice in the culture of silence among the various cluster community groups, it is important to emphasize that inter-cluster communication may still pose a problem, which ASHA may be unable to address. Considering the constraints of ASHA and success of cluster community approach in Unicef supported community based Maternal Child Health & Nutrition (MCHN) Project, it is quite reasonable to state that inclusion of community mobilisers (Bal Parivar Mitra) from within the cluster community group might well be an asset to the programme, who may actually bring about the task of spreading the spirit of NRHM. These set of functionaries may work in coordination to bring about the desired behaviour changes and decrease the social delays responsible for maternal and childhood mortality. It will also bring about the feeling of community participation and ownership. The programme is in its initial phase but has years ahead of it to bring visible changes at community level to make it a reality.

Key Words: ASHA, Cluster Community, Community Mobilisers, NRHM, Social Audit

Introduction

The National Rural Health Mission (NRHM)[1] is basically a strategy to address the issues related to the determinants of health in the improvement of quality of life of the citizen and socio- economic development of the country. It will especially cover 18 states where the indicators of health are below acceptable level. The goal of the mission is to improve the availability, accessibility and quality health care with community ownership, especially the unreached and disadvantaged poor, women and children through a keyperson i.e. Accredited Social Health Activist (ASHA).

The core strategies of NRHM include decentralized health planning and management at village and district level. Accredited Social Health Activist (ASHA) will play a major role in facilitating access to health services and contribute in strengthening the public health service delivery. It has been envisaged that one Accredited Social Health Activist (ASHA) will cover a population of one thousand to serve as the interface between the community and the health system. Community activist – ASHA will be pivotal for convergence of services at grass root level in coordination with the ANM, AWW's and Gram Vikas Panchayat Adhikari. She will be trained to advise rural community about sanitation, hygiene, contraception and immunization etc. She will provide treatment of minor ailments like diarrhoea, minor injuries and fever; she will also accompany patients to health facilities. She would also be expected to deliver Directly Observed Treatment Short-course (DOTS) for tuberculosis. She will be a depot holder of health products like ORS, IFA, chloroquine, Disposal Delivery Kits, Oral Pills and Condoms etc. She will act as a key informant and link person in an outbreak of health related events.

She will be a catalyst for involving the community in local health planning, increase utilization and accountability of existing health services. She would be a promoter of positive health practices.

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Unlike all other programmes in the past, NRHM has clearly laid down the guidelines of operationlization of decentralization and implementation of the strategy which undoubtly ensures the greater participation of the community.

Capacity building of ASHA and experiences of cluster community approach:

The success of any programme depends on the approach that it adopts, NRHM is not an exception. The success comes when the policies emerge from ground realities and are related to the concerned, realizing the actual difficulties[2]. The success story of UNICEF supported community based Maternal Child Health & Nutrition (MCHN) Project[3] at Agra stands true to it. One of the major innovations in this project was "Cluster Community Approach". The concept of Caste Community Clusters is an age-old phenomenon in a rural setting, as there exist 3-5 cluster community groups in each village. The intra cluster communication is better than the inter cluster communication. Even the caring practices at cluster community level are different from one cluster to another cluster. Therefore the issue is how to make ASHA - a better communicator, facilitator and service provider across different cluster community groups of the village. The social dynamics and social complexities are going to be greater constraints, which need to be clearly spelled out in the process of capacity building of ASHA.

The previous health programmes did not realize the ground realties of the community, which is divided into diverse socio-religious and economic groups, and it holds true for the uneven distribution of malnutrition, morbidity and mortality indicators among these socio-cultural groups residing in the rural area. The problem for ASHA may remain the same. The experiences of Village Health Guide Scheme in which overlooking the cluster community groups was one of the obstacle in the implementation of the scheme. The community based Maternal Child Health Nutrition project at Agra has empirically demonstrated success in terms of change in behaviour and practices, with substantial reduction in under five mortality. The clusters were identified by social mapping of the village. One community mobiliser in each cluster was identified and they were given three days training about maternal child health and nutrition care issues. The cluster community approach experimented under community based MCHN project at Agra can be well utilized in the capacity building programme of ASHA under NRHM assuming that there are already such women (**community influencer/mobiliser – 'Bal Parivar Mitra' in MCHN**) in every cluster who are acceptable to every one. And these local resources can be utilized as a member of ASHA team as community mobiliser, effective communicator and counsellor. These local women having the established creditability know the pulse of the community, and can influence her group. She can evoke community involvement and has the capacity of instilling confidence in the community.

While ASHA is an inter-cluster link, Bal Parivar Mitra acts as community mobilisers from each cluster. ASHA has been taken as a representative of entire village, which is comprised of heterogeneous sections of the society. This questions the very acceptance of ASHA by all the community members as an agent of health behaviour changes. Unlike it, Bal Parivar Mitra is identified from each community cluster group as an agent of social change so as to ensure the acceptability and sustainability. Therefore in the process of capacity building of ASHA, the thrust has to be given on social mapping of the villages, identification of community mobiliser's such as Bal Parivar Mitra and their training on issues related to reproductive child health & nutrition care. Imparting knowledge regarding various welfare concepts and training them like the "Bal Parivar Mitra" by using the pictorial Management Information System formats & training modules in their local language can bring desired behavioral changes, which can be instrumental in effectively bringing down the mortality, morbidity as well as malnutrition in women and children. Besides this, it will ensure community participation.

Situation analysis of Border District Cluster Strategy (BDCS) [6,7] revealed that delivery of the health care services provided by the health worker is not uniform. There is a large gap between demand and services. Community does not know who is service provider? Even if they know they are ignorant about when and where she will come to perform the task. Even if they know all this, they may be ignorant about the services community can take from her. Social bias may be one of the reasons for this non uniformity. On the part of worker there might be a preference for better

and well off families, while the marginalized section of the society living in the outskirts are left out by her. Another problem is the availability of the health worker at the distant villages of sub-centre where she is most required. This gap in services is expected to be filled by ASHA who herself will be in a precarious position by being responsible to the Gram Panchayat & at the same time is supposed to work under the guidance of ANM and AWW.

Social audit for community action:

Social audit of events & services, which has been undertaken in community based MCHN project, is a good example for initiating community action. Thus social audit may act as a successful tool for bringing desirable changes in the community in the area of health especially delay in recognition of seriousness of problem & taking decision to seek appropriate care at family level, and arranging the transport and money for reaching health facility at community level. To ameliorate the problems the community action has to be taken at the community level itself[4,5]. It will also lead them to critically analyze the actions at family and community level that might have been taken to save the life thereby empowering the community in triple A approach- Assessment, Action and Analysis. This is where the role of ASHA and the community mobilisers is instrumental. ASHA and Bal Parivar Mitra (community mobilisers) can coordinate effectively to cut down the social delays by in facilitating discussions on the issues during the meeting of Health & Welfare Committee ensuring collective wisdom for collective action.

In this context NRHM would consider to involve cluster community based mobilizers from each cluster community groups It is expected that they would serve to generate awareness and mobilize the communities for improving various health & nutrition care services, thus creating demand for services and increased need based response leading to quality convergent services. The functions of ASHA with ANM & AWW, Bal Parivar Mitra need to be defined more explicitly to bring a visible change and make this mission a reality rather than remaining rhetoric.

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National Rural Health Mission – opportunity for Indian Public Health Association

Sandip Kumar Ray*

Summary

Indian Public Health Association (IPHA) welcomes the release of National Rural Health Mission (NRHM) documents. It suggests that manpower requirements of the Community Health Centre (CHC) should be rationally determined on the basis of work and patient load of the CHC. Importance should be given on availability of simple & life saving equipment, female staff when male staff is not available. Safe drinking water, an adequate sanitation and excreta disposal facility through Panchayet Raj Institution (PRI) or privatization was proposed. Accredited Social Health Activist (ASHA) has been accepted more streamlining based on the community was suggested. Capacity building or training should be CHC based for grass-root level functionaries with incentive to Medical officer (MO). IPHA proposes to extend support in capacity building, development of manual for ASHA & other categories of health professional as well as Program Implementation Plan (PIP).

Key Words: NRHM, IPHA opportunity, BPHC, IMNCI, IDSP

Introduction

12th April 2005 was an auspicious day for the health sector of India, when Dr. Manmohan Singh, Hon'ble Prime Minister of India, launched the National Rural Health Mission for making necessary architectural correction in the basic health care delivery system of the country. The document has been disseminated to large number of the members of the Indian Public Health Association as well as to other public health professionals through the Indian Journal of Public Health[1].

In regard to the vision of the National Rural Health Mission (NRHM), some evidence based comments and suggestions have been made for consideration by the State and the Central Governments while implementing NRHM

Some Observations and some suggestions for consideration

The Vision of NRHM is to provide effective health care to rural population while it aims at architectural correction of health system to effectively handle increased allocations of fund, strengthening the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS).

CHC Workload issue

In this regard, some evidence-based observations from Community Health Centre (CHC) based study may help the government as guidance for the implementation of NRHM in right direction. Analysis of ten Block Primary Health Centers (BPHC) or CHC (as per Govt. of India norms. This term will be used henceforth) of a state revealed that average daily patient attendance ranges between 70 to more than 200 with an average of 150 patients per day. Patients were mainly coming for the illnesses like diarrhea, fever, Acute Respiratory Infection (ARI), worm infestations, skin conditions like scabies etc. In few BPHCs there were malaria cases. Excepting in 2 CHCs, which are situated very close to Sub Divisional (S. D) Hospitals, majority of the CHCs had an average patient admissions rate of around 250 per month. They constituted mainly of maternity cases, fever, diarrhea, poisoning, snakebite and injury cases. . Therefore at the time of resource allocation consideration should be made, which CHC should get more allocation based on their workload and disease load[2]

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Male Staff Issue

There was scarcity of Health Workers Male (HW-M) to the extent of 20-50% while 1 out of 10 sub centers had no Health Workers Female (HW-F). The scarcity of supervisory staff, Health Supervisors (HS) was relatively less. However it was observed that supervision appeared to be poor. One of the researcher observed that the knowledge of the supervisory staff was poorer on a specific subject than the HW-F. He found knowledge score of supervisors was found to be significantly higher than the supervisors in the intervention area. Supervisors were most of the time higher in age and had poor literacy level.[3]. At the time of in depth interview it was proposed that this supervisory cadre should be abolished and the budget allotted for this category of staff could be diverted for inclusion of more number of HW. Both HW-F & HS-F would need skill oriented training particularly for the skill of delivery and treatment of minor illness. This could be easily organized at CHC. Following suggestions of the community should be considered in future. Some states have already taken initiatives to address this issue.

1. Male staff vacancies should be filled in by female staff
2. Multipurpose worker training school should be re-started and male workers should also be trained
3. In that case selection of MPW should be made from the sub-centre villages with a minimum qualification as Higher Secondary with Science subject.
4. Supervisory training should be incorporated in their curriculum and skill-based training should be conducted preferably at the BPHC level or else at the sub district or district.

Preventive and Promotive services

Antenatal clinic was held at the CHCs every week once or twice depending on the patient load. Average beneficiaries ranges from 20 to 50 cases per week. Often BP and weight recording was not done because of non-functioning equipments or sometimes, because of poor motivation on the part of the ANM. Injection Tetanus Toxoid (TT) and Iron Folic Acid (IFA) tablets were given. Mercury of the BP machine sometimes comes out and may lead to dangerous situation. in four centers doctors did not have skills to perform mini-laporatomy due to lack of training. Routine immunization program was going on regularly. However, there was a shortage of cold chain equipment like Ice Lined Refrigerator (ILR), deep-freezers as after UNICEF has withdrawn the supply and no new supply is coming. Some of these equipments are in non-functional state as reported by the staff. Sometimes, government is taking adhoc measures in replacing the equipment. Activities under NRHM should include sustainable supply of these equipments. Lack of sterilization equipment for syringe and needle sterilization was not mentioned as already policy decision has taken to supply Auto disabled syringe. Supply and maintenance of BP instruments, weight machine should be managed from proposed fund at sub centre level[2].

Emergency Equipment supply infrastructural facilities, etc

Out of 10 BPHCs / CHC studied, there were separate operation theaters in 8 CHCs. But there was major shortage of Operation theater tables, light and other simple equipment like canula. Mucous Sucker machine and oxygen cylinders were available only at 50% of the CHCs studied. Medical Termination of Pregnancy (MTP) was done occasionally in those CHCs where interested trained General Duty Medical Officers were available & who did at least diploma in Gynecology and Obstetrics. The basic equipment suggested by the Medical Officer at the time of study were, Mucous Sucker Machine, Dilatation & Evacuation set, newborn resuscitation kit, I/V infusion sets, jelco, catgut, tourniquet, scalp vein set, stomach pump, delivery kit (instruments), labor table in adequate numbers depending upon the load (at least two), rubber cloth, folding chair & table for outreach session etc. But further consideration and evaluation of such requirement is needed at the time of implementation of NRHM with specific reference to architectural changes. The importance should be given to availability of simple and life saving equipment.

The staff and community members also suggested to have toilet facilities. Study also revealed that community should take responsibility in this regard to keep the toilets clean. Almost all the CHCs were having toilets but these could not be used due to very poor cleanliness and untidy nature as well as broken condition. Conditions at sub center level was further

poor as rented building did not have toilets at all. Female Health workers had to go to neighboring house for toilet facilities. It was also proposed that clean toilet and tube well for safe drinking water should be provided, maintained and managed locally with the involvement of Panchayet Raj Institution or through private agencies or NGO[2] .

CHC work load and referral

On an average 69 to 250 deliveries were conducted in CHCs per month. It was observed that community does not prefer delivery at those CHCs, which were situated close to Sub-divisional/District Hospitals or Medical colleges. It was also observed that one of the main reasons for shifting or referring the maternity cases (popularly known to the community as "delivery cases") to district hospitals or Medical College was pressure and threat from the patient family[2]. Other causes of referral were prolonged labour, fetal distress, eclampsia, and bad obstetric history. These were reported by almost all the medical officers who were interviewed. Involvement of Panchayet functionaries in motivating the community to have their delivery at CHC level should be undertaken. During the training of Traditional Birth Attendants (TBA) & ASHA, this issue should be emphasized.

Management Information System

The Management Information System was in a very poor shape. Majority of the health professionals do not understood the implications of "Nil reporting". The need for training is a must. The study also revealed that the skilled-based training should not be organized for the Medical officers' only but also for all the other categories of paramedical staff working at the Sub-center level. The suggestions were given for a corpus fund at the CHC level at the time of study. But it should be appreciated that NRHM has proposed to allocate funds for the Sub-centre too. The training for the Paramedical staff should be conducted at the BPHC level so that the work at the sub centre level never get disrupted due to too frequent training.

Vision ASHA

NRHM has provision of a female health activist in each village as its key components. **Every village/ large habitat will have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system[1].** Promote access to improved healthcare at household level through the female health activist (ASHA). A village health plan should be prepared through a local team headed by the Health & Sanitation Committee of the Panchayat.

The vision of ASHA was supported by this professional group. If it is properly implemented it can definitely fulfill some of the objective of ASHA. Earlier study by Ray et all at border district of West Bengal revealed that the community supported the idea of Link Worker (close to the concept of ASHA). The community suggested the following about Link Worker.

Criteria Suggested are: Daughter-in-law of village aged 25 to 30 yrs. preferably class X passed, completed family, employment on contractual basis, husband/ family willing, pleasant personality & will perform the following functions.

- Treatment of minor illness
- Referral
- Arrangement of transport
- Awareness generation of community
- Help Health Workers (HW-F) and act as a link
- Conduct delivery even
- Selected for each village & ward
- Honorarium on contractual basis at Rs. 700/ month

This was suggested by the PRI, opinion leader and health and ICDS functionaries. The association suggest that due consideration should be given on above qualitative research findings while finally formulating the criteria for ASHA and it should not be only "interface between the community and the public health system to promote access to improved healthcare at household level"[2].

Capacity Building related issue

The issue of capacity building should be rationalized. Most training program should be conducted at the CHC level with the small incentive to the Medical officers who will be trained at the district level or at the tertiary level institution. Emphasis should not be given not only on knowledge-based training but also on skill-based training. Two aspects on skill based training was emphasized as follows

- For Anganwadi workers (AWW), Health workers (HW) and link workers (ASHA like provider) skill based training on treatment of minor illnesses could be provided at the CHC level without involving any additional resource. The above categories of trainee may stand behind the Medical officer when he is conducting treatment at OPD. Medical officer will explain the treatment and referral as well as follow up could be made.
- All Traditional Birth Attendants (TBA) should be allowed to see how deliveries are conducted in the labour room to have hands on knowledge in this regard. Such efforts were made in some areas in the country by some medical officers as an initiative[4]. Furthermore TBA who are trained should be allowed to conduct deliveries at the sub-centre where HW-F is not staying. The key of that sub-centre should be kept with Panchayat.

Behavior Change for Communication

Study conducted by the six medical colleges of the state under the guidance of School of Tropical Medicine, Kolkata revealed that 69% of the people get information on health from the health workers. Around 40% got it from electronic media while less than 15% get the information from posters, hoarding. Focus discussion conducted at the time of formulation of Border District Project proposal also confirmed the view that posters were hardly understood by the people. Thus at the grass-root level more emphasis should given on interpersonal communication. ASHA in the Rural Health Mission can take this task. One should know that IEC does not mean posters, hoardings and the traditional way.

In conclusion it may be said that NRHM has made good initiative. As a professional body, IPHA will extend its full support. However, the following areas may be chosen for extending support initially.

Indian Public Health Association may extend their support in the following areas

1. Capacity building and sensitization of key public health Professionals of different regions of the country regarding key issues of NRHM through workshops as well as publication of special issue of Indian Journal of Public Health
   i. Disseminate through Indian Journal of Public Health to all the members and subscribers on Key issues of NRHM
   ii. Sensitization of Public Health Professionals on Key Program components under the NRHM and find out the ways of implementation
   iii. Sensitizing the Public Health Professionals on important Aspects of RCH II, *National Disease Control Programs (NDCP) and the Integrated Disease Surveillance Project (IDSP)* as well as on Integrated Management of Neonatal and Childhood Illness (IMNCI) program
   iv. Develop a booklet or manual for public Health Professionals on key components of RCH II, NDCP, IDSP & IMNCI
2. Help in the development of Manual for the ASHA and AWWs
3. Training of core trainers of ASHA other categories of health personnel in the different of states
4. Independent External Evaluation of NRHM Helping State in developing Project Implementation Plan (PIP)

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National Rural Health Mission

(2005-2012)

Mission Document

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PREAMBLE

Recognizing the importance of Health in the process of economic and social

development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstrearning the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public ***expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.***

The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

1. STATE OF PUBLIC HEALTH

- Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Union Budgetary allocation for health is 1.3% while the State's Budgetary allocation is 5.5%.
- Union Government contribution to public health expenditure is 15% while States contribution about 85%
- Vertical Health and Family Welfare Programmes have limited synergisation at operational levels.
- Lack of community ownership of public health programmes impacts levels of efficiency, accountability and effectiveness.
- Lack of integration of sanitation, hygiene, nutrition and drinking water issues.
- There are striking regional inequalities.
- Population Stabilization is still a challenge, especially in States with weak demographic indicators.
- Curative services favour the non-poor: for every Re.1 spent on the poorest 20% population, Rs.3 is spent on the richest quintile.
- Only 10% Indians have some form of health insurance, mostly inadequate
- Hospitalized Indians spend on an average 58% of their total annual expenditure
- Over 40% of hospitalized Indians borrow heavily or sell assets to cover expenses
- Over 25% of hospitalized Indians fall below poverty line because of hospital expenses

2. NATIONAL RURAL HEALTH MISSION – THE VISION

- The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

- The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.
- It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.
- It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.
- It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.
- It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.
- It seeks decentralization of programmes for district management of health.
- It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.
- It shall define time-bound goals and report publicly on their progress.
- It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

3. GOALS

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

4. STRATEGIES

(a) Core Strategies:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

- Formulation of transparent policies for deployment and career development of Human Resources for health.
- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in under served areas.

(b) Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promotion of Public Private Partnerships for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.
- Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

5. PLAN OF ACTION

COMPONENT (A): ACCREDITED SOCIAL HEALTH ACTIVISTS

- Every village/large habitat will have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.
- ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.
- She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.
- She will be trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations.
- She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat.
- She will be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.
- She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.
- Induction training of ASHA to be of 23 days in all, spread over 12 months. On the job training would continue throughout the year.
- Prototype training material to be developed at National level subject to State level modifications.
- Cascade model of training proposed through Training of Trainers including contract plus distance learning model
- Training would require partnership with NGOs/ ICDS Training Centres and State Health Institutes.

COMPONENT (B): STRENGTHENING SUB-CENTRES

- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
- Supply of essential drugs, both allopathic and AYUSH, to the Sub-centres.
- In case of additional Outlays, Multipurpose

Workers (Male) / Additional ANMs wherever needed, sanction of new Sub-centres as per 2001 population norm, and upgrading existing Sub-centres, including buildings for Sub-centres functioning in rented premises will be considered.

COMPONENT (C): STRENGTHENING PRIMARY HEALTH CENTRES

Mission aims at Strengthening PHC for quality preventive, promotive, curative, supervisory and Outreach services, through:

- Adequate and regular supply of essential quality drugs and equipment (including Supply of Auto Disabled Syringes for immunization) to PHCs
- Provision of 24 hour service in 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower.
- Observance of Standard treatment guidelines & protocols.
- In case of additional Outlays, intensification of ongoing communicable disease control programmes, new programmes for control of noncommunicable diseases, upgradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (I male, 1 female) would be undertaken on the basis of felt need.

COMPONENT (D): STRENGTHENING CHCs FOR FIRST REFERRAL CARE

A key strategy of the Mission is:

- Operationalizing 3222 existing Community Health Centres (30-50 beds) as 24 Hour First Referral Units, including posting of anaesthetists.
- Codification of new Indian Public Health Standards, setting norms for infrastructure, staff, equipment, management etc. for CHCs.
- Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.
- Developing standards of services and costs in hospital care.
- Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.
- In case of additional Outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

COMPONENT (E): DISTRICT HEALTH PLAN

- District Health Plan would be an amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition.
- Health Plans would form the core unit of action proposed in areas like water supply, sanitation, hygiene and nutrition. Implementing Departments would integrate into District Health Mission for monitoring.
- District becomes core unit of planning, budgeting and implementation.
- Centrally Sponsored Schemes could be rationalized/modified accordingly in consultation with States.
- Concept of "funneling" funds to district for effective integration of programmes
- All vertical Health and Family Welfare Programmes at District and state level merge into one common "District Health Mission" at the District level and the "State Health Mission" at the state level
- Provision of Project Management Unit for all districts, through contractual engagement of MBA, Inter Charter/Inter Cost and Data Entry Operator, for improved programme management

COMPONENT (F): CONVERGING SANITATION AND HYGIENE UNDER NRHM

- Total Sanitation Campaign (TSC) is presently implemented in 350 districts, and is proposed to cover all districts in 10th Plan.
- Components of TSC include IEC activities, rural sanitary marts, individual household toilets, women sanitary complex, and School Sanitation Programme.

- Similar to the DHM, the TSC is also implemented through Panchayati Raj Institutions (PRIs).
- The District Health Mission would therefore guide activities of sanitation at district level, and promote joint IEC for public health, sanitation and hygiene, through Village Health & Sanitation Committee, and promote household toilets and School Sanitation Programme. ASHA would be incentivized for promoting household toilets by the Mission.

COMPONENT (G): STRENGTHENING DISEASE CONTROL PROGRAMMES

- National Disease Control Programmes for Malari a, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme shall be integrated under the Mission, for improved programme delivery.
- New Initiatives would be launched for control of Non Communicable Diseases.
- Disease surveillance system at village level would be strengthened.
- Supply of generic drugs (both AYUSH & Allopathic) for common ailments at village, SC, PHC/CHC level.
- Provision of a mobile medical unit at District level for improved Outreach services.

COMPONENT (H): PUBLIC-PRIVATE PARTNERSHIP FOR PUBLIC HEALTH GOALS, INCLUDING REGULATION OF PRIVATE SECTOR

- Since almost 75% of health services are being currently provided by the private sector, there is a need to refine regulation
- Regulation to be transparent and accountable
- Reform of regulatory bodies/creation where necessary
- District Institutional Mechanism for Mission must have representation of private sector
- Need to develop guidelines for Public-Private Partnership (PPP) in health sector. Identifying areas of partnership, which are need based, thematic and geographic.
- Public sector to play the lead role in defining the framework and sustaining the partnership
- Management plan for PPP initiatives: at District/ State and National levels

COMPONENT (I): NEW HEALTH FINANCING MECHANISMS

A Task Group to examine new health financing mechanisms, including Risk Pooling for Hospital Care as follows:

- Progressively the District Health Missions to move towards paying hospitals for services by way of reimbursement, on the principle of "money follows the patient."
- Standardization of services – outpatient, in-patient, laboratory, surgical interventions- and costs will be done periodically by a committee of experts in each state.
- A National Expert Group to monitor these standards and give suitable advice and guidance on protocols and cost comparisons.
- All existing CHCs to have wage component paid on monthly basis. Other recurrent costs may be reimbursed for services rendered from District Health Fund. Over the Mission period, the CHC may move towards all costs, including wages reimbursed for services rendered.
- A district health accounting system, and an ombudsman to be created to monitor the District Health Fund Management , and take corrective action.
- Adequate technical managerial and accounting support to be provided to DHM in managing risk-pooling and health security,
- Where credible Community Based Health Insurance Schemes (CBHI) exist/are launched, they will be encouraged as part of the Mission.
- The Central government will provide subsidies to cover a part of the premiums for the poor, and monitor the schemes.
- The IRDA will be approached to promote such CBHIs, which will be periodically evaluated for

effective delivery.

COMPONENT (J): REORIENTING HEALTH/ MEDICAL EDUCATION TO SUPPORT RURAL HEALTH ISSUES

- While district and tertiary hospitals are necessarily located in urban centres, they form an integral part of the referral care chain serving the needs of the rural people.
- Medical and para-medical education facilities need to be created in states, based on need assessment.
- Suggestion for Commission for Excellence in Health Care (Medical Grants Commission), National Institution for Public Health Management etc.
- Task Group to improve guidelines/details.

6. INSTITUTIONAL MECHANISMS

- Village Health & Sanitation Samiti (at village level consisting of Panchayat Representative/s, ANM/ MPW, Anganwadi worker, teacher, ASHA, community health volunteers
- Rogi Kalyan Samiti (or equivalent) for community management of public hospitals
- District Health Mission, under the leadership of Zila Parishad with District Health Head as Convener and all relevant departments, NGOs, private professionals etc represented on it
- State Health Mission, Chaired by Chief Minister and co-chaired by Health Minister and with the State Health Secretary as Convener-representation of related departments, NGOs, private professionals etc
- Integration of Departments of Health and Family Welfare, at National and State level
- National Mission Steering Group chaired by Union Minister for Health & Family Welfare with Deputy Chairman Planning Commission, Ministers of Panchayat Raj, Rural Development and Human Resource Development and public health professionals as members, to provide policy support and guidance to the Mission
- Empowered Programme Committee chaired by Secretary HFW, to be the Executive Body of the Mission
- Standing Mentoring Group shall guide and oversee the implementation of ASHA initiative
- Task Groups for Selected Tasks (time-bound)

7. TECHNICAL SUPPORT

- To be effective the Mission needs a strong component of Technical Support
- This would include reorientation into public health management
- Reposition existing health resource institutions, like Population Research Centre (PRC), Regional Resource Centre (RRC), State Institute of Health & Family Welfare (SIHFW)
- Involve NGOs as resource organisations
- Improved Health Information System
- Support required at all levels: National, State, District and sub-district.
- Mission would require two distinct support mechanisms – Program Management Support Centre and Health Trust of India.

(A) PROGRAM MANAGEMENT SUPPORT CENTRE

- For Strengthening Management Systems-basic program management, financial systems, infrastructure maintenance, procurement & logistics systems, Monitoring & Information System (MIS), non-lapsable health pool etc.
- For Developing Manpower Systems – recruitment (induction of MBAs/CAs /MCAs), training & curriculum development (revitalization of existing institutions & partnerships with NGO & private sector. Sector Institutions), motivation & performance appraisal etc.
- For Improved Governance – decentralization & empowerment of communities, induction of IT based systems like e-banking, social audit and right to information.

(B) HEALTH TRUST OF INDIA

- Proposed as a knowledge institution, to be the

repository of innovation – research & documentation, health information system, planning, monitoring & evaluation etc.

- For establishing Public Accountability Systems – external evaluations, community based feedback mechanisms, participation of PRIs /NGOs etc.
- For developing a Framework for pro-poor Innovations
- For reviewing Health Legislations.
- A base for encouraging experimentation and action research.
- For inter & intra Sector Networking with National and International Organizations.
- Think Tank for developing a long-term vision of the Sector & for building planning capacities of PRIs, Districts etc.

8. ROLE OF STATE GOVERNMENTS UNDER NRHM

- The Mission covers the entire country. The 18 high focus States are Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Sikkim, Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, Mizoram Himachal Pradesh and Jammu & Kashmir. GoI would provide funding for key components in these 18 high focus States. Other States would fund interventions like ASHA, Programme Management Unit (PMU), and upgradation of SC/PHC/CHC through Integrated Financial Envelope.
- NRHM provides broad conceptual framework. States would project operational modalities in their State Action Plans, to be decided in consultation with the Mission Steering Group.
- NRHM would prioritize funding for addressing inter-state and intradistrict disparities in terms of health infrastructure and indicators.
- States would sign Memorandum of Understanding with Government of India, indicating their commitment to increase contribution to Public Health Budget (preferably by 10% each year), increased devolution to Panchayati Raj Institutions as per 73rd Constitution (Amendment) Act, and performance benchmarks for release of funds.

9. FOCUS ON THE NORTH EASTERN STATES

- All 8 North East States, including Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura, are among the States selected under the Mission, for special focus.
- Empowerment to the Mission would mean greater flexibilities for the 10% committed Outlay of the Ministry of Health & Family Welfare, for North East States.
- States shall be supported for creation/upgradation of health infrastructure, increased mobility, contractual engagement, and technical support under the Mission.
- Regional Resource Centre is being supported under NRHM for the North Eastern States.
- Funding would be available to address local health issues in a comprehensive manner, through State specific schemes and initiatives.

10. ROLE OF PANCHAYATI RAJ INSTITUTIONS

The Mission envisages the following roles for PRIs:

- States to indicate in their MoUs the commitment for devolution of funds, functionaries and programmes for health, to PRIs.
- The District Health Mission to be led by the Zila Parishad. The DHMwill control, guide and manage all public health institutions in the district, Sub-centres, PHCs and CHCs.
- ASHAs would be selected by and be accountable to the Village Panchayat.
- The Village Health Committee of the Panchayat would prepare the Village Health Plan, and promote intersectoral integration
- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
- PRI involvement in Rogi Kalyan Samitis for good

hospital management.

- Provision of training to members of PRIs.
- Making available health related databases to all stakeholders, including Panchayats at all levels.

11. ROLE OF NGOs IN THE MISSION

- Included in institutional arrangement at National, State and District levels, including Standing Mentoring Group for ASHA
- Member of Task Groups
- Provision of Training, BCC and Technical Support for ASHAs/DHM
- Health Resource Organizations
- Service delivery for identified population groups on select themes
- For monitoring, evaluation and social audit

12. MAINSTREAMING AYUSH

- The Mission seeks to revitalize local health traditions and mainstream AYUSH infrastructure, including manpower, and drugs, to strengthen the public health system at all levels.
- AYUSH medications shall be included in the Drug Kit provided at village levels to ASHA.
- The additional supply of generic drugs for common ailments at Subcentre/ PHC/CHC levels under the Mission shall also include AYUSH formulations.
- At the CHC level, two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian Public Health System (IPHS) model.
- Single doctor PHCs shall be upgraded to two doctor PHCs by mainstreaming AYUSH practitioner at that level.

13. FUNDING ARRANGEMENTS

- The Mission is conceived as an umbrella programme subsuming the existing programmes of health and family welfare, including the RCHII, National Disease Control Programmes for Malaria, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme.
- The Budget Head For NRHM shall be created in B.E. 2006-07 at National and State levels. Initially, the vertical health and family welfare programmes shall retain their Sub-Budget Head under the NRHM.
- The Outlay of the NRHM for 2005-06 is in the range of Rs.6700 crores.
- The Mission envisages an additionality of 30% over existing Annual Budgetary Outlays, every year, to fulfill the mandate of the National Common Minimum Programme to raise the Outlays for Public Health from 0.9% of GDP to 2-3% of GDP
- The Outlay for NRHM shall accordingly be determined in the Annual Budgetary exercise.
- The States are expected to raise their contributions to Public Health Budget by minimum 10% p.a. to support the Mission activities.
- Funds shall be released to States through SCOVA, largely in the form of Financial Envelopes, with weightage to 18 high focus States.

14. TIMELINES (FOR MAJOR COMPONENTS)

Merger of Multiple Societies June 2005 Constitution of District/State Mission Provision of additional generic drugs at SC/PHC/CHC level December 2005 Operational Programme Management Units 2005-2006 Preparation of Village Health Plans 2006 ASHA at village level (with Drug Kit) 2005-2008 Upgrading of Rural Hospitals 2005-2007 Operationalizing District Planning 2005-2007 Mobile Medical Unit at district level 2005-08.

15. OUTCOMES

(a) National Level:

- Infant Mortality Rate reduced to 30/1000 live births
- Maternal Mortality Ratio reduced to 100/100,000
- Total Fertility Rate reduced to 2.1
- Malaria mortality reduction rate –50% upto 2010, additional 10% by 2012
- Kala Azar mortality reduction rate: 100% by 2010 and sustaining elimination until 2012

- Filaria/Microfilaria reduction rate: 70% by 2010, 80% by 2012 and elimination by 2015
- Dengue mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
- Japanese Encephalitis mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
- Cataract Operation: increasing to 46 lakhs per year until 2012.
- Leprosy prevalence rate: reduce from 1.8/10,000 in 2005 to less than 1/10,000 thereafter
- Tuberculosis DOTS services: Maintain 85% cure rate through entire Mission period.
- Upgrading Community Health Centers to Indian Public Health Standards
- Increase utilization of First Referral Units from less than 20% to 75%
- Engaging 250,000 female Accredited Social Health Activists (ASHAs) in 10 States.

(b) Community Level:

- Availability of trained community level worker at village level, with a drug kit for generic ailments
- Health Day at Anganwadi level on a fixed day/ month for provision of immunization, ante/post natal checkups and services related to mother & child healthcare, including nutrition.
- Availability of generic drugs for common ailments at Sub-centre and hospital level
- Good hospital care through assured availability of doctors, drugs and quality services at PHC/ CHC level
- Improved access to Universal Immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme
- Improved facilities for institutional delivery through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families
- Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission
- Provision of household toilets
- Improved Outreach services through mobile medical unit at district level

16. MONITORING AND EVALUATION

- Health MIS to be developed upto CHC level, and web-enabled for citizen scrutiny
- Sub-centres to report on performance to Panchayats, Hospitals to Rogi Kalyan Samitis and District Health Mission to Zila Parishad
- The District Health Mission to monitor compliance to Citizen's Charter at CHC level
- Annual District Reports on People's Health (to be prepared by Govt/NGO collaboration)
- State and National Reports on People's Health to be tabled in Assemblies, Parliament
- External evaluation/social audit through professional bodies/NGOs
- Mid Course reviews and appropriate correction

National Rural Health Mission- Frequently Asked Questions

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I. Profile, Components, and Strategies

1. Why a National Rural Health Mission?

The National Common Minimum Programme spells out the commitment of the Government to enhance Budgetary Outlays for Pub lic Health and to improve the capacity of the health system to absorb the increased outlay so as to bring all round improvement in public health services. The National Rural Health Mission seeks to provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralization.

2. What is the coverage of the National Rural Health Mission (NRHM)?

The NRHM covers the entire country, with special focus on 18 states where the challenge of strengthening poor public health systems and thereby improve key health ind icators is the greatest. These are Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura.

3. Is NRHM a new programme of the Government of India?

The NRHM is basically a strategy for integrating ongoing vertical programmes of Health & Family Welfare, and addressing issues related to the determinants of Health, like Sanitation, Nutrition and Safe Drinking Water. The National Rural Health Mission seeks to adopt a sector wide approach and aims at systemic reforms to enable efficiency in health service delivery. NRHM subsumes key national programmes, namely, the Reproductive and Child Health II project, (RCH II) the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Project (IDSP). NRHM will also enable the mainstreaming of Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH).

4. What are the strategies of the NRHM?

While providing a broad framework for operationalization, NRHM lists a set of core and supplementary strategies to meet its goals. *Core strategies of NRHM include:* Decentralized village and district level health planning and management, appointment of Accredited Social Health Activist (ASHA) to facilitate access to health services, strengthening the public health service delivery infrastructure, particularly at village, primary and secondary levels, mainstreaming AYUSH, improved management capacity to organize health systems and services in public health, emphasizing evidence based planning and implementation through improved capacity and infrastructure, promoting the non profit sector to increase social participation and community empowerment, promoting healthy behaviors, and improving intersectoral convergence. *Supplementary Strategies* include regulation of the private sector to improve equity and reduce out of pocket expenses, foster public–private partnerships to meet national public health goals, re-orienting medical education, introduction of effective risk pooling mechanisms and social insurance to raise the health security of the poor, and taking full advantage of local health traditions.

5. Does the NRHM exclude provision of Health Care to urban populations?

Under the urban component of RCH II and the National Disease Control Programmes, curative and referral interventions and other programmes for urban poor would continue as before. A Task Group on Urban Health is being constituted to recommend strategies for urban poor.

II. Institutional Framework and Fund Flows

1. What is the institutional set up at National, State and District levels?

The Mission Steering Group under the Chairmanship of the Union Minister for Health & Family Welfare will provide policy guidance and operational oversight at the National level. Ministerial / Secretary level representatives of Planning Commission, Rural Development, Panchayati Raj, Human Resource Development and Health and Family Welfare Secretaries of four States and ten public health professionals nominated by the Prime Minister will be members of the Mission Steering Group. At the State level, the State Health Mission shall be led by the Chief Minister. It shall be co-chaired by the Health Minister with the State Health Secretary, as convenient, and representation from related Departments, NGOs, private professionals etc. The District Health Mission shall be led by the Chairman, Zila Parishad, and be convened by the District Head of the Health Department. It shall have representation from all relevant Departments, NGOs and private professionals. However, States can choose their State specific models. The district and sub district arrangements for the Total Sanitation Campaign would be similar to those of the NRHM, and the activities of the Sanitation guided by the District Health Mission.

2. What will be the role of the State Governments under the NRHM?

The State Governments have been part of the Stakeholder Consultations for finalization of the strategy of the Mission. The States shall enter into a Memorandum of Understanding (MoU) with the Government of India, stating their agreement to the policy

framework of the Mission and the timelines and performance benchmarks against identified activities. The States shall establish State and District Health Missions, and integrate the multiple Societies for Health and Family Welfare Programmes at State and District levels, as envisaged under the NRHM. A State Action Plan shall be formulated reflecting the needs of the Health Sector, including the determinants of Health, like Sanitation, Nutrition and Safe Drinking Water, and the unmet needs which shall be addressed under the NRHM. The State shall also commit to undertake systemic reform, including devolution of powers to Panchayati Raj Institutions and decentralization of the programme to district levels as envisaged under NRHM, and ensure smooth fund flow, Technical and MIS support.

3. What will be the roles of the State and District Health Missions?

The State Health Mission shall prepare the roadmap for architectural correction of the Health System, including merger/integration of vertical structures; delegation and decentralization of administrative and financial powers; empowering the PRIs; preparation of Operational Guidelines for the implementation of the Mission; logistics arrangements; disease surveillance; IEC; and MIS. The District Health Mission shall control, guide and manage all public health institutions in the district and at sub-district levels. It will be responsible for preparation and implementation of an integrated District Action Plan in respect of funds received from all funding agencies into the District Health Fund. It shall guide the micro planning for selection and training of ASHAs, organization of Health Camps at Anganwadi levels, services related to immunization and institutional delivery, mainstreaming of AYUSH infrastructure, supply of drugs, upgrading CHCs to IPHS, utilization of Untied Fund at Sub-centre level, and strengthening outreach services through operationalization of mobile medical unit. It shall also ensure intersectoral convergence among related Departments at district and sub-district levels. Above all, the DHM shall ensure the accountability of the public health system to the Panchayati Raj Institutions and to the community.

4. What are the flexibilities available to the States under the NRHM?

The NRHM provides broad operational framework for the Health Sector. Suggestive guidelines are being issued on key interventions like ASHA, Indian Public Health Standards (IPHS), institutional deliveries, immunization, preparation of District Action Plan, role of Panchayati Raj Institutions etc. The States shall have flexibility to project operational modalities in their State Action Plans, which would be decided in consultation with the Mission Steering Group. The NRHM is being

launched as a framework of partnership among Government of India, related Departments of the Government, especially Departments of Women & Child Development, Drinking Water Supply, Panchayati Raj, and Development of North Eastern Region State Governments, Panchayat Raj Institutions, NGOs, and private health providers, and. The detailing of strategies will continue during the Mission with the combined effort of all the stakeholders.

5. What is the Outlay of NRHM?

The Outlay of the NRHM for 2005-06 is Rs.6713 crores. The Outlay of the Mission in subsequent years will be dependent on the Outlay of the Ministry of Health and Family Welfare. The State-wise allocation under NRHM for 2005-06 are **annexed**.

6. Can the States expect an increased outlay in the coming years?

The Budget Outlay of the Ministry of Health and Family Welfare has increased by 30% in 2005-06 over the previous financial year. The States would prepare comprehensive Action Plans for NRHM, indicating priorities for funding, which shall be covered under the increased Outlays expected in the coming years.

7. What shall be the State contribution under the NRHM?

The State Action Plan shall reflect the Outlays available for Public Health expenditure under Centrally Sponsored Schemes, State Budget, State Finance Commission, major Bilateral funded Programmes and Schemes funded by Planning Commission like Rashtriya Samvikas Yojana etc. The States are required to sign MoU with the GoI, committing a minimal increase of 10% for Public Health expenditure in the State Budget each year.

8. What is the fund flow mechanism?

The States will be given an advance, indication of funds to be devolved. State Action Plan would be prepared, which would be funded through a financial envelope for RCH-II and funding under NDCP. The Societies for Health and Family Welfare programmes shall merge into one integrated Society at State and District level to enable "funneling" of funds. The NRHM Budget Head would retain Sub-Budget Heads for the erstwhile Societies.

9. What is the role of Panchayati Raj Institutions (PRI) in the NRHM?

One of the core strategies of the NRHM is to empower local governments to manage, control and be accountable for public health services at various levels. The Village Health & Sanitation Committee (VHC), the standing committee of the Gram Panchayat (GP) will provide oversight of all NRHM activities at the village level and be responsible for developing the Village Health Plan with the support of the ANM, ASHA, AWW and Self Help Groups. Block level Panchayat Samitis will co-ordinate the work of the GP in their jurisdiction and will serve as link to the DHM. The DHM will be led by the Zila Parishad and will control, guide and manage all public health institutions in the district. States will be encouraged to devolve greater powers and funds to Panchayati Raj Institutions.

III. Operational Issues

1. What are key activities for the Year 2005-2006?

Broadly speaking, the common activities under NRHM, which are uniformly applicable across all States/UTs over and above those proposed under ongoing programmes like RCH and National Disease Control Programmes,, are as follows:

- Constitution of State and District Health Missions
- Merger of Health and Family Welfare Societies
- Preparation of State Action Plan, which identifies sectoral needs and priorities
- Finalizing performance benchmarks for MoU
- Signing of MOU between State and GOI
- Preparation of District Action Plans.
- Upgrading two CHCs in every district to the level of Indian Public Health Standards, including the provision for two rooms in these CHCs for bringing AYUSH practitioners under the same roof.
- Formation of Rogi Kalyan Samitis
- Immunization strengthening through induction of Auto Disabled Syringes and arrangement for alternate vaccine delivery at immunization sites.

- Organizing mobile medical services at district level.
- Organizing Health Camp at AWW level on a fixed day in a month for assured services for women and child health care.
- Provision of household toilets.
- Strengthening institutional delivery under Janani Suraksha Yojana (JSY) through provision of escort and referral services by ASHA & subsidized hospital services for BPL women.
- Establishing systems to increase accountability of health systems to PRIs.

ü Selection and training of ASHA, including provision of drug kits

✓ Organizing Health Melas as a platform to inform and educate the public on NRHM

ü Provision of generic drugs, both AYUSH and allopathic, at village, SC/PHC/CHC level, for common ailments.

Some activities as at ✓ above shall be specially funded in the 18 high focus States.

2. What additional inputs will States receive in Year 1?

- Rs. 20 lakhs/CHC to two CHCs in every district for bringing them on par with IPHS.
- Maintenance grant of Rs. 1 lakh per CHC, after constitution of Rogi Kalyan Samiti at that level.
- Untied fund of Rs. 10,000 per Sub-centre.
- Supply of additional drugs (allopathic and AYUSH) at Sub-centre, PHC and CHC level
- Mobile Medical Unit for district
- 50% districts in EAG states to get Rs. 10 lakhs/ district for district planning
- Funds for training of ASHAs

3. When are State, District and Village Action Plans due?

State and District Action Plans are expected to be formulated within the first six months. Village Action Plans can be formulated during the second year.

4. What should State Action Plans include?

State Action Plans in Year I should include outlays for RCH II, National Dis ease Control Programme and the Integrated Disease Surveillance Programme. The State Action Plan would also include funds under AYUSH, Finance Commission grants- in-aid, Rashtriya Sam Vikas Yojana, external bilateral funding, and large NGO grants. Even though budgeting would remain separate for better convergence, the outlays and programmes to improve sanitation, nutrition etc. should also be reflected in the State Action Plan. Once the District Plans are ready, the State Action Plan should be based on those Plans.

5. What should a District Action Plan include?

For 2005-2006, districts should consolidate existing resources within the HFW sector, plan for convergence with nutrition, water and sanitation, and focus on identifying areas in the district with poor indicators and greatest need of financial resources. After Year 2 detailed District Action Plans, based on Village Health Plans should be developed by the DHM. States are expected to procure technical assistance for districts to support the development of District Action Plans. Under RCH and other donor funded programmes, some districts have already prepared Action Plan for RCH. These will need to be reworked, to include other components under NRHM. The districts, which did not get such funding support, will receive funds for district planning @ Rs. 10 lakhs per district (in EAG States).

6. Will NRHM provide for additional project management cost?

Project Management cost for all districts is covered under the financial envelope of RCH II. 18 high focus States shall make contractual engagement of skilled professionals, viz. CA, MBA & MIS specialist at State and District level for enhancing capacities of programme management and technical support to the NRHM.

7. How to integrate Water, Sanitation, and Nutrition in NRHM?

The institutional arrangement for the NRHM as well as Total Sanitation Campaign will be the same at District and Village levels. However budgeting for the two programmes will remain separate. Integration with

ICDS implies joint planning, us e of AWC as the hub of the NRHM interventions in the village, joint reporting and monitoring on common indicators, and engagement with the AWW as a key figure in village planning and implementation.

8. What is the budget profile of NRHM? What will separate sub budget lines look like?

In Year 1 (2005-2006) there will be no separate Budget Head for NRHM. Creation of a new Budget Head for NRHM will be from 2006 onwards. The existing programmes would maintain sub-Budget Heads under the omnibus NRHM Budget Head.

9. Will the States have to sign separate MoUs for RCH-II and NRHM?

There will be only one MOU, subsuming the MOU for all programmes integrated under NRHM. Signing of this MoU shall be the precondition to release of second tranche of funds in October 2005.

10. What are key performance benchmarks for Year 1?

Performance benchmarks under NRHM would include performance indicators in respect of all integrated programmes. In addition, NRHM requires the following activities to be completed in Year 1:

- Constitution of State and District Health Missions
- Merger of Health and Family Welfare Societies
- Signing of MOU for NRHM between State and GOI

IV. Key Activities

1. Can states continue to implement existing community health workers programmes?

The States would have flexibility in this regard. If States have ongoing community worker/volunteer programme, they can continue to engage with those already selected. However, ASHA must be **primarily a woman resident of the village**, preferably, in the age group of 25 to 45 years, **'Married/Widow/ Divorced'** with **formal education up to Eighth Class**. Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

2. Is ASHA to be selected on a population-based norm?

States are free to select ASHA as per their own requirements. The norms are "1 ASHA for 1000 population". For areas like deserts and hilly terrain, these norms may be relaxed.

3. Is ASHA a paid employee?

ASHA is not a paid employee. She would not be entitled to any pay or ho norarium, but be eligible for compensation for services provided under various schemes and programmes of GoI and State Governments - for institutional delivery under Janani Suraksha Yojana, for completion of DOTS treatment under National TB Control Programme, promotion of household toilets under Total Sanitation Campaign, etc. under the overall guidance of the District Health Mission.

4. How will ASHA be selected?

After going through a community mobilization process, a panel of suitable persons would be drawn up and placed before Gram Sabha. The necessary formalities regarding the selection would be done by the Village Health & Sanitation Committee.

5. Will the ASHA get a formal letter of appointment?

No, but the minutes of the approval process (in Gram Sabha or Village Health Committee meeting) will be recorded. The Village Health Committee would enter into an agreement with the ASHA *(as in the case of the Village Education Committee and Sahayogini- in Sarva Shiksha Abhiyan)*

6. Is ASHA to be universal?

Currently ASHA is envisaged in the EAG States, Assam and Jammu & Kashmir.

7. Who is ASHA accountable to?

ASHA would be accountable to the community through the Gram Panchayat. She would be guided by the Anganwadi Worker and the ANM. She would report to the Village Health & Sanitation Committee of the Gram Panchayat.

8. Will ASHA be getting a drug kit?

Yes, a drug kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India. The kit will be provided to ASHA after adequate training.

9. What will be her primary roles and responsibilities?

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

Frequently Asked Questions on IPHS:

1. What is IPHS?

Indian Public Health Standards are a set of standards envisaged to improve the quality of health care delivery in the country under the National Rural Health Mission.

2. What is the need for IPHS?

The health care system in India has expanded considerably over the last few decades, however, the quality of services is not uniform, due to various reasons like nonavailability of manpower, problems of access, acceptability, lack of community involvement, etc. Hence, standards are being introduced in order to improve the quality of public health level.

3. Who will be recommending these standards?

A Task Group under Director General of Health Services was constituted to recommend the Standards. The IPHS is based on its recommendation.

4. Who will it be applicable to?

At present these standards are being applied only to the Community Health Centres (CHCs). As a first step, requirements for a Minimum Functional Grade of a Community Health Centre are being prescribed. Further upgradation will be proposed after these minimum requirements have been met. Subsequently, standards for PHC and SC shall also be developed.

5. Why only for CHCs?

The NRHM aims at strengthening hospital care for rural areas. CHC is a 30-bedded hospital providing specialist care in medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. However due to various reasons, the functioning of CHCs has not been as desired. These centres are the First Referral Units as far as curative care is concerned and are also the link between primary care and tertiary care. With the availability of specialist care in these centres, it was felt that these would be the right breaking ground.

6. Why another set of standards?

Although it is true that there are existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource- intensive. Hence a less resource intensive standard suited to the requirements of the system has been developed.

7. What is hoped to be achieved by these standards?

Under the NRHM, the Accredited Social Health Activist (ASHA) is being envisaged in each village to promote the health activities. With ASHA in place, there is bound to be a groundswell of demands for health services and the system needs to be geared to face the challenge. In order to ensure availability and quality of services, we are now establishing the Indian Public Health Standards for CHCs so as to provide a yardstick with which to measure the services being provided in the CHCs. With these standards it will be possible to objectively grade Centres and take up remedial action accordingly.

8. What are the various recommendations under IPHS?

- Improvement in the availability of specialist services in the CHCs by ensuring availability of all the sanctioned specialists. Additional sanction of the post of Anesthetist and Public Health Manager is also envisaged.
- Strengthening support staff, by recommending a Public Health Nurse and an ANM in all these Centres, in addition to the existing staff.

- Norms for infrastructure, equipment, laboratory, Blood storage facilities, and drugs have been formulated.
- Guidelines for management of routine and emergency cases under Nationa l Health programmes are being provided to all CHCs, to maintain uniformity, and also optimum standardized treatment.

9. How will compliance to these Standards be ensured?

- Monitoring and evaluation would be both internal as well as external.
- Training of medical as well as para medical staff.
- Charter of Patients' Rights would be prominently displayed in all these centres.
- Rogi Kalyan Samitis would be formed to improve accountability.
- The District Health Mission would monitor the progress for maintenance of standards at facility level.

10. How will the Mission address the issues of absentee doctors in rural areas?

Availability of doctors and paramedics in rural areas is important to the success of the Mission. The States will examine the possibility and modalities for having district level cadres for doctors and Block level cadres for ANMs as resolved in the 7th Conference of the Central Council of Health & Family Welfare Ministers, in August 2003. The District Health Missions will have greater flexibility for engaging the services of private doctors on contractual basis to provide services in public health institutions. Most importantly, the States shall indicate their commitment to devolve the funds and programmes for health and family welfare to Panchayati Raj Institutions under the NRHM, to ensure effective accountability of the public health providers at corresponding levels. The Mission also proposes to involve Professional Medical Associations viz. Indian Medical Association (IMA), Federation of Obstetricians and Gynaecologists of India (FOGSI) etc. to build peer and professional support for the programme.

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  NRHM – Mission Documents

  NRHM- Frequently Asked Questions

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